



**N.B. This manual will be subject to some minor changes between now and August 2007 as and when the final changes to MMC and PMETB policy become known. The printed version of this manual will not be issued until the RCoA is satisfied that it is as accurate as possible.**

# **THE CCT IN ANAESTHESIA**

## **I: General Principles**

**A manual for trainees and trainers**

**Edition 1: January 2007**

**1st Edition dated: 26 January 2007**

**Replacing *The CCST in Anaesthesia* Edition 2 dated: April 2003**

This edition of *The CCT in Anaesthesia I: General Principles*, revises the *CCST in Anaesthesia I: General Principles* 2<sup>nd</sup> Edition dated April 2003. This edition includes a re-written section on assessment and appraisal, and some generic material has been moved from Parts II, III and IV, and updated.

The term “sub-specialty” to describe the options available at the intermediate, higher and advanced levels of training has been replaced with “special interest” to conform with PMETB terminology.

The majority of the other changes have been made to reflect the introduction of seamless training in August 2007.



## PREFACE

This is one of four training manuals published by the Royal College of Anaesthetists (RCoA) which describe the programme of training leading to a Certificate of Completion of Training (CCT) in anaesthesia. The manuals are:

- *The CCT in Anaesthesia I: General Principles*
- *The CCT in Anaesthesia II: Competency Based Basic Level Specialty Training and Assessment*
- *The CCT in Anaesthesia III: Competency Based Intermediate Level Specialty Training and Assessment*
- *The CCT in Anaesthesia IV: Competency Based Higher and Advanced Level Specialty Training and Assessment*

***The CCT in Anaesthesia I: General Principles* contains generic material that is relevant to all parts of the training programme. Parts II, III and IV must be read in conjunction with Part I.**

The manuals were originally published as *The CCST in Anaesthesia* following consultation and feedback from Specialist Societies, Regional Advisers, RCoA Tutors, Programme Directors, RCoA Council Members and individual anaesthetists which was reviewed and developed by working parties that reported to the RCoA Training Committee and College Council. This edition was approved by the Postgraduate Medical Education and Training Board on 18 January 2007.

The RCoA Training Committee consists of members from College Council, the Bernard Johnson Advisors for less than full-time trainees and overseas trainees, the Lead Dean for anaesthesia, and representatives from England, Northern Ireland, Scotland and Wales, the Regional Advisers and the Intercollegiate Board for Intensive Care Medicine.

The Committee will be pleased to receive comments on this Training Programme from both trainers and trainees. These should be addressed to the Medical Secretary of the RCoA Training Committee at [medsec@rcoa.ac.uk](mailto:medsec@rcoa.ac.uk).

This manual is reviewed regularly with an implementation date for any changes being not less than 6 months after their publication date. Amended pages are sent to Regional and Deputy Regional Advisers, College Tutors and Programme Directors. An updated version of the manual is maintained on the College website [www.rcoa.ac.uk](http://www.rcoa.ac.uk). Please work from the latest version.

Occasionally Council or the Training Committee have to take decisions that may affect the immediate interpretation or application of specific topics in these manuals. These will be published in *Guidance for Trainers* and, if necessary, earlier by letter to all Regional and Deputy Advisers, College Tutors and Programme Directors, and on the College website.

## ACKNOWLEDGEMENTS

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The following Specialist Societies and Associations provided and continue to provide input to the curriculum:

Age Anaesthesia Association  
Anaesthetic Research Society  
Anaesthetists in Management  
Association of Burns and Reconstructive Anaesthetists  
Association for Low Flow Anaesthesia  
Association of Anaesthetists of Great Britain and Ireland  
Association of Cardiothoracic Anaesthetists  
Association of Dental Anaesthetists  
Association of Paediatric Anaesthetists  
British Association of Immediate Care  
British Malignant Hyperthermia Association  
British Medical Acupuncture Society  
British Ophthalmic Anaesthesia Society  
British Society of Orthopaedic Anaesthesia  
Difficult Airway Society  
European Society for Regional Anaesthesia  
Group of Anaesthetists in Training  
Intensive Care Society  
Neuroanaesthesia Society of Great Britain and Ireland  
Obstetric Anaesthetists' Association  
Paediatric Intensive Care Society  
Pain Society  
Plastic Surgery and Burns Anaesthetists  
Resuscitation Council  
Society for Computing and Technology in Anaesthesia  
Society for Intravenous Anaesthesia  
Vascular Anaesthesia Society

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# EXECUTIVE SUMMARY

## INTRODUCTION

### Aim

The aim of the programme leading to the award of a CCT in anaesthesia is to produce high quality anaesthetists with a broad range of skills that will enable them to practise as consultant anaesthetists in the United Kingdom.

### Duration of training

**Indicative duration** To obtain a CCT in anaesthesia a trainee has to follow a competency based, specialty training (ST) programme covering basic, intermediate and higher and/or advanced levels of training in anaesthesia, pain management and Intensive Care Medicine (ICM). The indicative duration of training is 7 years, of which:

- basic level will *normally* last 2 years (ST years 1 and 2);
- intermediate level will *normally* last 2 years (ST years 3 and 4); and
- higher and/or advanced level will *normally* last 3 years (ST years 5, 6 and 7).

The actual duration of an individual's training will be determined by the rate at which they achieve the necessary competences.

**Minimum duration** The minimum duration of formal training is normally seven years. In exceptional circumstances, if a trainee can prove that they have acquired all the necessary competences in a shorter time and have the confidence and competence to be a consultant, the College may recommend to PMETB that a CCT should be awarded after less than seven years.

### Underlying principles

The following information summarises the principles of the UK training programme which trainees must fulfil to gain a CCT.

The principles of the UK CCT training programme are that it:

- is competency based;
- is planned;
- is evaluated;
- has clear objectives;
- is supervised;
- is delivered by appropriately appointed trainers;
- allows time for study; and
- accommodates the specific career needs of individuals.

There are certain generic professional skills, essential to the training of all specialists that should be covered. These include:

- attitude and behaviour
- communication;
- presentation;
- audit;
- teaching;
- ethics and law: and
- management.

## **BASIC LEVEL TRAINING (ST years 1 and 2)**

The normal duration of basic level training will be 2 years of which 21 months must be in anaesthesia and 3 months in ICM, but special arrangements will be made for trainees entering ST year 2 from the Acute Care Common Stem programme who may have undertaken more ICM training. Modular training is encouraged whenever possible but it is recognised that this can cause practical difficulties in smaller hospitals.

### **The first six months**

At the start of their training trainees must pass an initial assessment of competency comprising:

- preoperative assessment;
- general anaesthesia for ASA I or II patients (including equipment and anaesthetic machine checks);
- rapid sequence induction;
- CPR skills; and
- clinical judgement, attitudes and behaviour.
- Until this initial assessment of competency is passed trainees cannot practice anaesthesia without immediate supervision.

During the first six months trainees should learn the basic principles of safe and effective anaesthesia, resuscitation, and both the prevention and treatment of pain. Emphasis should be placed on the role of the anaesthetist in the peri-operative care of the surgical patient. Thus a guided introduction to the pre-operative assessment and post-operative care is just as important as the practice of anaesthesia. The following basic units should be covered within this period:

- care of the patient;
- anaesthetic equipment;
- basic techniques in anaesthesia;
- basic techniques in local anaesthesia; and
- anaesthetic pharmacology.

### **Training for the next eighteen months**

The following areas of basic training should be covered in this period:

- obstetric analgesia, anaesthesia and resuscitation;
- pain management/control/treatment;
- the upper airway and its problems;
- peri-operative care of the patient for major surgery;
- anaesthesia for day case surgery;
- paediatric anaesthesia;
- anaesthesia in the elderly;
- specific anaesthesia and medical problems; and
- ICM (trainees who have filled *full time* basic level posts in ICM can count up to 3 months of this training towards their basic level training in Anaesthesia). Trainees who come start the anaesthesia CCT programme via Acute Care Common Stem (ACCS) training may also have acquired some intermediate level ICM competences in that programme.

In this period trainees will widen their experience to obtain the Basic Level Training Certificate and become eligible to move to intermediate level training in ST3. By the end of this stage trainees should be able to:

- undertake the anaesthetic care of most routine cases;
- assist in the anaesthetic care for more complex surgery;
- provide anaesthetic care for routine obstetric practice;

- organise, with the surgical team, an emergency list; identify potential problems and seek appropriate help;
- understand the principles underlying the care of patients in Intensive Care and High Dependency Units;
- understand the principles of pain management;
- participate in audit; and
- pass an assessment of knowledge and certain skills by examination.

### **INTERMEDIATE LEVEL TRAINING (ST years 3 and 4)**

These two years, undertaken by all trainees, form a balanced programme of intermediate level training which:

- exposes trainees to more training of the type done at basic level but at an intermediate level; and
- introduces the trainee to examples of more demanding aspects of anaesthesia practice.

#### **Key Units**

There are six “Key Units” of training during ST years 3 and 4. With the exception of ICM all trainees are required to receive the equivalent of at least one month (but not normally more than 3 months) of training in each unit. For ICM, 3 months training is obligatory; trainees who start the anaesthesia CCT programme via Acute Care Common (ACCS) training may already have acquired the necessary intermediate level ICM competences in that programme. The ‘Key Units’ are:

- Cardiac / Thoracic
- ICM
- Neuroanaesthesia
- Obstetrics
- Paediatric anaesthesia
- Pain management, chronic & acute

#### **General Units**

There are seven “General Units” of intermediate training, which it is expected that all trainees in ST years 3 and 4 will receive. The “General Units” are:

- Day surgery
- ENT
- General surgery / Gynaecology / Urology (+/- Transplantation)
- Orthopaedics
- Regional Techniques
- Trauma and accidents
- Vascular

#### **Additional Units**

Finally there are five special interest “Additional Units” of intermediate training that may or may not be available depending on the distribution and availability of services locally. It is expected that trainees in ST years 3 and 4 will receive training in at least some of these special interests and, on occasion, one or more specialist units of training could be linked together. For instance, maxillo-facial / dental, ENT and some experience with plastic surgery might be linked in a single head and neck unit of training and then assessed as a single entity. The “Additional units” are:

- Diagnostic imaging, anaesthesia & sedation
- Maxillo-facial / Dental

- Ophthalmic surgery
- Plastics / Burns
- Miscellaneous

## **HIGHER AND ADVANCED LEVEL TRAINING (ST years 5, 6 and 7)**

The aim of higher and advanced training undertaken in ST years 5, 6 and 7 is to prepare trainees for independent professional practice in their consultant post of choice. These three years combine a clinical programme designed to meet individual career choices.

There is no one standard model of training for these years. The College sets some broad criteria to ensure that training has an appropriate balance but within these, there is considerable latitude for differing approaches. These final 3 years will seek to develop:

- the transition from basic competency to becoming skilled in specific aspects of anaesthesia;
- the ability to manage patients with significant co-morbidities; and
- organisational skills so that their contribution to an operating list is as part of a team and ensures continuity and smooth running of cases by anticipating problems and planning ahead.

### **General Duties**

Normally there should be an aggregate of 12 months 'general duties'<sup>1</sup> within ST years 5, 6 and 7. As a minimum every trainee *must* undertake at least six months of this type of training.

### **ICM**

A minimum of 6 months intermediate level ICM training must be completed during ST years 3-7 eg 3 months in ST3/4 and 3 months in ST5 or 4 months in ST3/4 and 2 months in ST5; the exact split will depend on local circumstances. Trainees who start the anaesthesia CCT programme via ACCS training may already have acquired some of the necessary ICM competences in that programme.

### **Higher training**

The programme allows for trainees to become skilled at a higher level in particular aspects of anaesthetic practice. This should not be seen as a syllabus. The availability of clinical material will very often determine what can be achieved. It is recommended that trainees should move through these training blocks based on periods of 3 months. For some this may be shortened, other trainees may wish to extend the period of their training. Higher training includes:

- Cardiac/Thoracic
- Day surgery
- Ear, Nose and Throat (Otorhinolaryngology)
- General surgery
- Maxillo-facial/Dental
- Neuroanaesthesia
- Obstetrics
- Orthopaedics

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<sup>1</sup> 'General duties' means that a variety of elective surgery plus the core topics agreed by the Union of European Medical Specialists (UEMS) in 1998 are substantially covered.

- Ophthalmic
- Paediatrics
- Pain Management
- Plastics/Burns
- Trauma and accidents
- Vascular

## Advanced Training

**Major special interests** Some trainees will want to gain advanced training in specific special interest areas of anaesthesia and ICM. Six special interests are identified for advanced training, based on the demand for consultants trained in these areas. For these special interests a period of training of at least 6 months and up to 12 months can be followed which will allow the trainee to become expert in that particular field and consequently be able to apply for a consultant post with a significant clinical commitment in the special interest. The special interest areas are:

- Cardiac/Thoracic
- Neuroanaesthesia
- Obstetrics
- Paediatric Anaesthesia
- Pain management
- Intensive Care Medicine

**Other special interests** The identification of the six special interest areas does not preclude trainees undertaking periods of training in other special interests, such as anaesthesia for maxillo-facial surgery or plastic surgery and burns anaesthesia, which exceed 3 months.

## Generalist Training

The training of a general anaesthetist is based on the assumption that such a specialist will normally be employed in a general hospital and must be capable of dealing with any patient who might be admitted whilst they are on-call, until specialist assistance becomes available or until transfer. This also encompasses supporting trainees who might find themselves dealing with a situation beyond their competence.

For those seeking generalist training a broad, balanced programme should normally include obstetric, paediatric, neuro and cardiothoracic anaesthesia at the higher level and the trainee must have completed the ICM training at intermediate level specified on the previous page. The intention would be for the successful trainee to seek a consultant post in a hospital where this broad range of anaesthetic skills would be of particular value.

## Research

Research is regarded by the RCoA as being integral to the development of anaesthesia, intensive care and pain management. Every trainee should be able to evaluate new developments in their specialty thus preparing themselves for their future career as a consultant. To achieve this, trainees require experience in research methods so that they can:

- learn to pose relevant research questions, formulate hypotheses, design simple research projects, understand the statistical evaluation of such projects, and know how to draw valid conclusions;
- develop and maintain a system of continuous learning in order to keep abreast of major clinical and research developments; and
- in the context of training, learn to apply audit principles to their own work, and to clinical practice.

A *maximum* of one year of research can be counted towards a CCT.

## **ASSESSMENT**

Throughout the anaesthetic training programme all trainees undergo summative assessments designed to assess whether they have reached specified standards in the training programme, to quantify experience, and to estimate the individual trainee's eligibility to progress to further stages of training, or to a career post.

Following the introduction of Foundation Year training and a study of assessment techniques, the RCoA has decided that common tools and documentation should be used for workplace based assessment, unless other formats are explicitly required such as *The Initial Assessment of Competency*. The tools to be used are:

- Multi- Source Feedback
- Mini-Clinical Assessment Evaluation Exercise
- Direct Observation of Procedural Skills
- Case Based Discussion

Formal assessments of knowledge must be passed before a trainee can progress from Basic to Intermediate training and from Intermediate to Higher training. These assessments form the FRCA Primary and Final Examinations or prospectively approved equivalent qualifications.

## 1: INTRODUCTION

Postgraduate anaesthetic training in the UK produces high quality anaesthetists with a broad range of skills appropriate to the needs of the NHS. Visits to anaesthetic departments by the Royal College of Anaesthetists (RCoA), and meetings of Regional Advisers, Programme Directors, Examiners and RCoA Tutors demonstrate a continuing enthusiasm for training the next generation of consultants. A central theme of the Training Programme is to recognise this goodwill and, wherever possible, to incorporate successful, local initiatives.

### 1.1: Aim

The aim of the programme leading to the award of a CCT in anaesthesia is to produce high quality anaesthetists with a broad range of skills that will enable them to practise as consultant anaesthetists in the United Kingdom.

### 1.2: Postgraduate Medical Education and Training Board (PMETB)

The PMETB requires that a training programme leading to a Certificate of Completion of Training (CCT) in Anaesthesia must be 'competency based'. The training and assessment of trainees has to reflect this philosophy which has two essential components:

- competence in a trainee describes possession of the knowledge, skills and attitudes required to undertake safe clinical practice at a level of confidence commensurate with stated objectives; and that
- professional practice means more than the performance of clinical skills, no matter how complex. It very importantly carries a built-in commitment to standards and the attitudes which will maintain those standards throughout life.

### 1.3: The NHS Litigation Authority (NHSLA)

The NHSLA is a Special Health Authority responsible for handling negligence claims made against NHS bodies in England<sup>2</sup>. The NHSLA has issued standards expected of Trusts of which Standard 2, the 'Competent & Capable Workforce' is particularly relevant to training. Section 5 defines the documentation that each Trust must hold relating to the management of trainees, their supervisory meetings and the verification of clinical skills. The NHSLA has three levels of accreditation, above level 0:

- **Level 1: 2.5** As a minimum the approved document(s) detailing the procedures to ensure that all medical staff in training (STs, F1 and F2 trainees) are appropriately supervised during their clinical placements must include a description of the:
  - roles and responsibilities, both across the organisation and locally
  - system for ensuring that effective supervision is in place for all medical staff in training in all areas of the organisation
  - requirements in relation to the frequency and timing of supervisory meetings
  - systems to ensure that medical staff in training have the basic clinical skills required before they work independently
  - process for monitoring the effectiveness of all of the above
- **Level 2: 2.5** The organisation can demonstrate compliance with the standards set out within the approved document(s) which describes a systematic approach to the

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<sup>2</sup> The Welsh Risk Pool and the Scottish Clinical Negligence and Other Risks (Non-Clinical) Indemnity Scheme (CNORIS) fulfil similar roles to the NHSLA. In Northern Ireland each Trust has its own risk assessment and negligence scheme.

supervisory process for medical staff in training on initial appointment and ongoing thereafter described at level 1, in relation to the:

- system for ensuring that effective supervision is in place for all medical staff in training in all areas of the organisation
  - systems in place to ensure medical staff in training have the basic clinical skills required before they work independently
- **Level 3: 2.5** The organisation can demonstrate monitoring the effectiveness of the minimum requirements contained within the approved document(s) which describes a systematic approach to the supervisory process for medical staff in training on initial appointment and ongoing thereafter described at level 1, in relation to the:
- system for ensuring that effective supervision is in place for all medical staff in training in all areas of the organisation
  - systems in place to ensure medical staff in training have the basic clinical skills required before they work independently
  - where the monitoring has identified deficiencies, recommendations and action plans have been developed and changes implemented accordingly.

These standards emphasise the need for the assessment of competence and the responsibility of documenting competences and the achievement of training objectives. The implication for trainees and trainers is that training curricula must list the competences that have to be achieved and completed satisfactorily at each stage of training. The necessary knowledge, skills and attitudes have therefore been defined for all aspects of training and all three must be assessed. During the training process, it is expected that both trainees and trainers will comply with the guidance issued by the General Medical Council (GMC) and ICACCST.

#### **1.4: Abbreviations**

To save repetition, a list of commonly used abbreviations is given in Appendix A.

#### **1.5: Further advice**

The first point of contact for information concerning a trainee's training or career planning is this curriculum in conjunction with *Guidance for Trainers* and the *Regulations for FRCA Examinations*. The latter documents are available on the training and examination pages of the College website [www.rcoa.ac.uk](http://www.rcoa.ac.uk) and, like the CD version of the curriculum supplied to every trainee, can be searched electronically for key words. Most questions can be answered by reference to these documents.

The next point of contact is the College Tutor of the department in which the trainee is training. If the College Tutor is unable to give the necessary guidance then the Regional Advisor should be asked for advice.

Only if the College Tutor or Regional Advisor cannot help should a trainee contact the College's Training Department for advice because inevitably the Training Department will have no knowledge of the trainee's personal circumstances.

## 2: PRINCIPLES OF THE TRAINING PROGRAMME

### 2.1: Introduction

The CCT programme in anaesthesia is constructed so that all anaesthetists have the same core skills. Flexibility is introduced in the latter years of training such that individual career aspirations, or those of the NHS, can be catered for with a short lead-in time. For instance if there is less requirement for cardiac anaesthetists and more for pain specialists, the lead time to effect this would be only two years. In a similar way, anaesthetists have a broad-based training and 'refreshing' or 'retraining' of someone who is basically competent can be redirected appropriately for workforce needs.

The training of anaesthetists will occur in UK posts and programmes approved by PMETB or in other posts and programmes for which prospective approval has been given.

Departments in which training occurs must comply with the regulations and recommendations of the relevant national Departments of Health, PMETB and the RCoA. From time to time, the RCoA issues guidance on standards of practice.<sup>3</sup>

Doctors responsible for training are expected to comply with the regulations and recommendations of the GMC.

#### Royal College of Anaesthetists

The College has a Training Department. All trainees are required to register for training. Copies of the RITA forms and any correspondence related to their individual training are held at the College. A CCT date is estimated, usually on entry to ST year 3. This is altered if the necessary competences (including examinations) are not obtained or other circumstances prevail (such as sick leave or maternity leave) by the expected date.

### 2.2: Progression through the CCT programme

**Indicative duration** To obtain a CCT in anaesthesia a trainee has to follow a competency based, specialty training (ST) programme covering basic, intermediate and higher and/or advanced levels of training in anaesthesia, pain management and Intensive Care Medicine (ICM). The indicative duration of training is 7 years, of which:

- basic level will *normally* last 2 years (ST years 1 and 2);
- intermediate level will *normally* last 2 years (ST years 3 and 4); and
- higher and/or advanced level will *normally* last 3 years (ST years 5, 6 and 7).

**Actual duration** The actual duration of an individual's training will be determined by the rate at which they achieve the necessary competences. By the end of the programme the trainee should feel confident to practise independently as well as recognise that advice or help from colleagues be sought for unusual cases. For administrative reasons it may not always be possible for the Programme Director to fast-track trainees who achieve competences ahead of schedule.

**Minimum duration** The minimum duration of formal training is normally seven years. In exceptional circumstances, if a trainee can prove that they have acquired all the necessary competences in a shorter time and have the confidence and competence to be a consultant, the College may recommend to PMETB that a CCT should be awarded after less than seven years.

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<sup>3</sup> *Good Practice*, The Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland, 2002: *Guidelines for the Provision of Anaesthetic Services*, Royal College of Anaesthetists, 1999.

### 2.3: Schools of Anaesthesia

All the hospitals in the UK that train anaesthetists are contained in Schools of Anaesthesia. The Schools are functional units, usually within Deanery boundaries (although they occasionally cross Deaneries) that are able to provide the whole of training required for completion of a CCT. There are 29 Schools of Anaesthesia in the UK.

Hospitals within a School will generally be expected to offer experience and training in anaesthesia for elective and emergency general surgery, urology, trauma and orthopaedics, obstetrics and gynaecology, ENT and oral surgery, day case surgery and surgery for children excluding neonates. In addition, experience in pain management, resuscitation techniques and intensive care medicine should be provided. Experience in Emergency Medicine will require an Accident and Emergency department, which is staffed and operational 24 hours a day.

Within a School of Anaesthesia there are anaesthetists appointed as:

- Programme Director (a Deanery appointment)
- Regional Adviser (a College appointment)
- Deputy Regional Advisor (a College appointment)
- College Tutors (one for each hospital, with more for those with a lot of trainees)

In addition there is a variable contribution of secretarial and administrative support from the Deanery.

The number of hospitals in a School of Anaesthesia varies, but it is usually between five and ten. This is dependant on local geography and an effort is made to reduce the distances that a trainee may be expected to travel. There is at least one tertiary hospital within each School where specialist anaesthesia training occurs.

Single specialty hospitals that provide units of specialised training will form parts of Schools of Anaesthesia in order to complement the overall provision of training within the approved training programme.

For an individual trainee, basic level training occurs in a small number of hospitals, usually one but it may be up to three hospitals. The majority of this is organised as rotations which ensures that the necessary clinical exposure is met to complete the competences required for the first years of training. Occasionally a secondment is necessary to fill any areas that might be missing; sometimes this occurs because of local reconfiguration of services. There is a designated person (sometimes a Director of Basic Level training specifically within the School) who ensures that the rotations are composed appropriately.

The Programme Director organises the rotations to ensure that all the units of training are covered. Some modules (such as anaesthesia for cardiac surgery, neurosurgery and sometimes paediatric surgery) are only available in tertiary hospitals. Completion of basic and intermediate level training is confirmed locally by issue of certificates, copies of which are sent to the College.

Specialty Advisory Committees within each Deanery are usually chaired by the Regional Advisor and should include the College Tutor(s) from each hospital, a less than full-time training advisor, and Deanery and trainee representatives. These ensure that standards of training are maintained and problems or issues for individual trainees are discussed.

The introduction of the run-through grade in August 2007 means there may have to be organisational changes to ensure that the clinical experiences needed are gained at the appropriate times. There may be teething problems in some Schools of Anaesthesia if there is an imbalance in numbers progressing from basic to intermediate levels of training.

## 2.4: Responsibility for training in the workplace

Competency based training relies on assessments made during clinical service. The responsibility for the organisation, monitoring and efficacy of this training and assessment is shared by a variety of authorities:

- PMETB is responsible for approving posts and programmes for training.
- The RCoA is responsible for:
  - determining the learning objectives and competences of training;
  - advising PMETB and the Postgraduate Dean on the arrangements for organising and monitoring in-service training made by Schools of Anaesthesia and hospitals;
  - funding the Bernard Johnson Advisors who provide strategic advice on equality and diversity issues within training programmes; and
  - evaluating the training of individual trainees and recommending to PMETB the award of Certificates of Completion of Specialist Training (CCT).
- The Postgraduate Dean is responsible:
  - to PMETB for the quality management of the training programme.
  - for organising the Record of In-training Assessment (RITA) and an Annual Review for each trainee.
  - for the overall training arrangements in each Trust. The Clinical Tutor acts as the Dean's officer within the trust and is responsible for the educational environment and in some cases, aspects of generic training.
- The Local Specialty Training Committee:
  - reports to the Postgraduate Dean and is responsible for local arrangements for in-service training, but may delegate many of these administrative functions to the School of Anaesthesia; and
  - has responsibility for deciding what evidence of progress in training will be reviewed at appraisal and evaluated at the RITA.
- Programme Directors organise the rotations to ensure that all units of training are covered.
- Regional Advisors are responsible for representing the policies and views of the College in all relevant matters within their Region.
- The School of Anaesthesia is responsible for organising and monitoring the training scheme and individual trainees.
- The Clinical Directorate for anaesthesia within each hospital is responsible for delivering in service training in accordance with the principles adopted by PMETB, the RCoA, the Postgraduate Dean and the School of Anaesthesia.
- College Tutors are responsible for the training and assessment arrangements in their hospitals (see Section 4.3)<sup>4</sup>.

## 2.5: Units of training

The programme is composed of 'Units of Training', some of which are compulsory, others are optional. The units cater for general and special interest clinical areas as well as non-clinical subjects eg research, medical education and information technology. Each unit is described in terms of:

- the subject area;
- the required knowledge;
- the required skills;
- the required attitudes and behaviour;
- workplace training objectives for the trainee;
- for some specialist areas, the training environment,

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<sup>4</sup> See also *The Regional Advisors' Handbook*, 1998 and *The College Tutor - Roles and Responsibilities*, 2002

Only in a few cases will a minimum period of experience and /or a minimum number of cases be specified, because assessment should be based on competence, not numbers or time.

## 2.6: Appraisal and assessment

There will be regular appraisal and assessment within the training programme. Progress at various points in training is dependent on successful assessment.

Examinations of knowledge are one of several assessment methods used within the programme. The syllabus for the examination of basic level knowledge is the total content of the units contained in *The CCT in Anaesthesia II*. The syllabus for the examination of intermediate level knowledge is the total content of the units contained in *The CCT in Anaesthesia III*.

## 2.7: Supervision

Teaching and learning clinical anaesthesia requires that consultants and trainees work together in clinical practice.

**Clinical supervision** Every trainee must at all times be responsible to a consultant. That consultant must be available to advise and assist the trainee as appropriate. Sometimes this will require the consultant's immediate presence but on many occasions less direct involvement will be acceptable. Supervision is a professional function of consultants and they will be able to decide what is appropriate for each circumstance in consultation with the trainee. The safety of an individual hospital's supervision arrangements is the concern of the departmental and hospital management and it is necessary for them to agree local standards and protocols that take account of their particular circumstances. Clinical supervision is discussed in more detail in Section 5.

**Educational supervision**<sup>5</sup> Every trainee must have a nominated educational supervisor to oversee their individual learning.

## 2.8: Out of Hours cover for emergency services

Out of hours work for trainees largely involves providing services for emergencies. Such out of hours work makes different demands upon the anaesthetist. Both the clinical work and the experience of working in the hospital with reduced, out of hours service must be learned through experience. Whenever trainees are learning new aspects of emergency work they must have close clinical supervision.

The service requirements of hospitals, however, will often necessitate that trainees undertake more out of hours emergency cover than is needed for their training. A balance therefore must be maintained between the service and training requirements of out of hours work: service must not undermine the necessity for training out of hours. This must be reviewed by evaluating the whole training scheme; out of hours emergency work must not prevent the trainee from meeting the standards of the agreed competences on schedule. Out of hours duties apply *pro rata* (weekdays and weekends) to less than full-time trainees.

There is sometimes pressure for trainees during their anaesthetic units of training to provide out of hours cover for intensive care units and vice versa. As far as possible this should be

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<sup>5</sup> see footnote 3

discouraged although the College recognises that sometimes service needs may make this unavoidable.

## **2.9: Simulators**

The RCoA encourages the use of simulators for relevant aspects of postgraduate training in anaesthesia especially for events of high importance but infrequent occurrence (as exemplified by anaphylaxis), for situations where there might be a high risk to patients and for team building and working under pressure. Simulators are also used as assessment tools in the Primary FRCA Examination.

### 3: ENTRY TO THE TRAINING PROGRAMME

#### 3.1 Direct entry

Direct entry to the anaesthetic CCT programme is by competitive application under nationally agreed arrangements.

#### 3.2: ACCS entry

Acute Care Common Stem (ACCS) training is a two-year introductory course of training in anaesthesia, acute medicine, emergency medicine and intensive care medicine (ICM). As such it is accepted by PMETB as an element of the relevant curricula for the four specialty CCT programmes.

Entry to ACCS training will be by competitive application under nationally agreed arrangements. When applying for ACCS training trainees will be asked to specify the specialty they want to pursue for a CCT.

The duration and content of each ACCS specialty module may vary between Deaneries, but for anaesthesia the minimum syllabus will be that for the Initial Assessment of Competence and for ICM the minimum will be Section 7 of the basic syllabus for anaesthesia and might also include part or all of Section 4 of the intermediate syllabus for anaesthesia.

Trainees who complete ACCS training will normally join the anaesthesia CCT programme at an appropriate point in ST year 2. The subsequent content and duration of an individual's anaesthetic CCT training will depend on the competences already achieved in during ACCS training. A trainee who completed all or part of the intermediate level syllabus for ICM<sup>6</sup> during ACCS training will not normally have to repeat these competences provided that they have been successfully assessed and recorded.

ACCS trainees intending to follow an anaesthetic CCT programme will normally be expected to have passed the FRCA Primary MCQ Examination of knowledge before completing ACCS training.

#### 3.3: Entry from Fixed Term Specialist Training Appointments (FTSTA)

Entry to the anaesthetic CCT programme from FTSTAs will be by competitive entry under arrangements made by the postgraduate Deans. Such trainees will join the anaesthesia CCT programme at an appropriate point in the anaesthesia training programme determined by the competences already achieved in earlier training.

#### 3.4: Less than full-time (LTFT) trainees

The European Medical Directive states that:

“Part-time training shall meet the same requirements as full-time training, which shall differ only in the possibility of limited participation in medical duties to a period of at least half that of full-time trainees, including on-call duties.”

This is interpreted to mean that LTFT trainees should, *pro rata*, undertake the same out-of-hours work as full-time trainees, including weekend on-call duties. General advice on LTFT training is contained in the “Gold Guide”.

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<sup>6</sup> *The CCT in Anaesthesia* Part III Appendix 4

After appointment in open competition, any trainee with Deanery agreed eligibility can request to train on a less than full time basis. The training programme will be delivered on a *pro rata* basis for those who are eligible and have Deanery support. Each region has a LTFT training advisor who works with the Regional Advisor and the local Deanery to ensure that the needs of those trainees are met. One of the Bernard Johnson Advisors provides strategic advice to the RCoA in the needs of part time trainees and is a member of the RCoA Training Committee.

### 3.5: Re-entering training after a break

Requests from doctors who want to re-enter training after a break will be dealt with on an individual basis by the RCoA Training Committee in accordance with PMETB policy.

For those who have continued to practise anaesthesia (for instance in a Staff and Associate Specialist Grade (SASG) appointment or in a post overseas) the grade and year of re-entry will be dependent on the level of previous training. For instance, those who can demonstrate that they have satisfactorily completed 2 years of substantive career posts or 2 years of approved intermediate level training and can verify that they have met all the intermediate level competences for the award of the *Intermediate Level Training Certificate*,<sup>7</sup> could provisionally be placed in ST year 5.

**Re-orientation** Trainees returning to the specialty after a substantial break will require re-orientation. This will vary with the length of the break and the nature of any medical work the trainee has been engaged in during the interim. The Local Specialty Training Committee should ask the appropriate College Tutor to monitor the trainee's induction and progress and in the light of that to make recommendations, with evidence, to the RCoA Training Committee about the trainee's future training programme. The RCoA Training Committee will take this evidence into account when estimating the CCT date.

**Past training** When deciding on an appropriate entry point for an anaesthetist returning to training after a break, training undertaken more than five years previously should not normally be counted. The RCoA Training Committee approves exceptions to this on an individual basis.

### 3.6: Principles for calculating training time

**LTFT training** As described in Section 3.4, LTFT trainees should undertake, *pro rata*, the same out-of-hours work as full-time trainees, including weekend on-call duties.

#### **Locum and Fixed Term Training posts: recognition towards a CCT**

- If a trainee wants time spent in a FTSTA, FTTA or LAT post to be recognised towards CCT training, the form at Appendix B must be completed and submitted to the Medical Secretary of the RCoA Training Committee by the Regional Adviser.
- Time spent in an FTSTA, FTTA or LAT post must be properly documented and the relevant competences assessed to the standards specified in this manual, if it is to be recognised towards a CCT.
- *Fixed Term posts*
  - Normally a maximum of two years in FTSTA and FTTA posts can be assessed towards ST years 1 to 4 of the CCT programme.
- *Locum posts*
  - Locum Appointments for Service (LAS) cannot count towards CCT training.
  - The RCoA Training Committee will only assess Locum Appointment Training (LAT) experience *after* the trainee has obtained a substantive ST post.

<sup>7</sup> See *The CCT in Anaesthesia III: Competency Based Training and Assessment Intermediate Level Training* Section 4.6.

- A LAT post at basic level i.e. contributing to ST years 1 and 2, must be at least three months and no longer than six months duration.
- A maximum of two years in a LAT post at intermediate level i.e. contributing towards ST years 3 and 4, may be counted towards a CCT.
- A LAT post can count towards a CCT if it:
  - is followed by a substantive post (in normal circumstances, the substantive post should immediately follow the locum post);
  - is supported by the Local Specialty Training Committee;
  - covers the necessary programme of training specified in this Training Guide; and
  - the assessment of competences is completed as it is for those in substantive posts.
- Exceptions to the above will be considered on an individual basis provided that the training programme and assessment procedures have been followed in all respects as for a “run-through” training post.

**Sickness, parental and maternity leave** In a competency based programme trainees are to be assessed and signed off on the basis of competences achieved not the time taken to obtain them. Thus, normally, periods of absence due to sickness, parental or maternity leave are irrelevant. In the event of prolonged absence a period of re-orientation may be needed before further competences can be taught and assessed. Further advice can be found in Appendix C.

**Military service** Absence on military operations by full time or reserve members of the Defence Medical Services will be treated in the same way as for absence due to sickness. It is very possible that with careful planning such trainees may be able to acquire and be assessed for competences whilst on military duty.

### **Recognition of training outside the United Kingdom**

- *Recognition of basic training* The first twelve months of anaesthetic training may be undertaken abroad in a suitable prospectively approved training post.
- *Recognition of intermediate level training* Anaesthetic training at intermediate level undertaken abroad will be considered on a case by case basis by the RCoA's Training Committee in accordance with PMETB policy. Doctors who have not followed a complete programme of training *prospectively* approved by PMETB cannot be awarded a CCT but will have to apply, at the end of their UK training, to PMETB for a Certificate of Eligibility for Specialist Registration under PMETB Article 14.
- *Recognition of higher and advanced level training* Higher and advanced level training taken abroad as Off-Rotation Training (see Section 6 of *The CCT in Anaesthesia IV: Higher and Advanced Level Specialty Training and Assessment*) must be *prospectively* approved by the RCoA Training Committee, have clearly identified objectives, have named supervisors both in the UK training scheme and overseas who are responsible for ensuring the objectives are met and requires an agreement from the overseas institution to provide an assessment of the trainee's performance on completion of their attachment.

**Training year** The date an individual's indicative training year starts is determined by the Local Specialty Training Committee and is not necessarily the chronological date from the beginning of training.

## 4: THE DELIVERY OF TRAINING AND EDUCATION

The RCoA supports the GMC's view that *all* doctors have a professional obligation to contribute to the education and training of other doctors<sup>8</sup>. The instruction of trainees can be undertaken by consultants, SAS grade doctors and other trainees. Trainees may teach other trainees both formally in tutorials etc and in clinical situations where this is agreed by their supervising consultant. Clinical teaching situations will often involve the senior trainee in supervising the junior but the overall responsibility must rest with the nominated consultant supervisor (see Section 5.3). In addition there may be contributions from other health care professionals eg nurses, physiotherapists, pharmacists, basic scientists and health care managers.

### 4.1: Principles of delivering training and education

The RCoA recognises that the example of trainers and teachers has a powerful influence upon the standards of conduct and practice of every trainee, whether an undergraduate or a qualified doctor in training<sup>9</sup>. It follows that all those involved in training and teaching should recognise and meet their responsibilities<sup>10</sup>. In particular:

- Any anaesthetist, consultant or SAS grade doctor, who is involved in the training or education of trainees should themselves be aware of the educational objectives of the training programme and participate actively in the optimal construction and delivery of the programme.
- Consultants, SAS grade doctors and others involved in teaching must fulfil the CPD requirements for the clinical appraisal process and to the satisfaction of the RCoA.
- Trainers and teachers should take the necessary steps to acquire the skills of a competent teacher.<sup>11</sup>

### 4.2: The organisation of training and education

The primary responsibility for learning lies with the trainee. The infrastructure of training and education is there to facilitate this.

**Educational Supervisor** Every trainee must have an educational supervisor. The supervisor's role is to help the trainee to plan their training and reach personal and institutional objectives. In some anaesthetic departments the College Tutor may be the educational supervisor for all the trainees. If this is the case they must ensure that they have sufficient time and resources to undertake the duty in accordance with accepted good practice in educational supervision.

#### **Trainers**

- A trainer is normally a consultant who has responsibilities for the clinical teaching and educational supervision of trainees, including responsibility for appraisal and assessment. The GMC defines the personal and professional attributes required for this role.<sup>12 13 14</sup> To be a trainer the consultant must adhere to the principles described in 4.1 and be appointed in accordance with the criteria described in Appendix D.

<sup>8</sup> *The doctor as teacher*, GMC 1999, paragraph 4.

<sup>9</sup> *The doctor as teacher*, GMC 1999, paragraph 1

<sup>10</sup> *Good medical practice*, GMC 1998, paragraph 10

<sup>11</sup> *The doctor as teacher*, GMC 1999, paragraph 5

<sup>12</sup> *The doctor as teacher*, GMC 1999, paragraphs 8 & 9

<sup>13</sup> *Good medical practice*, GMC 1998, paragraph 8

<sup>14</sup> *Recommendations on the training of specialists*, GMC 1987, paragraph 16 (12) (a).

- *SAS grade anaesthetists as trainers*
  - The RCoA recognises that SAS grade doctors have a valuable role to play in training. For SAS grades who want to be trainers possession of the FRCA is not a prerequisite but, like consultants, they must fulfil the RCoA's CPD requirements; this is essential for those areas where they have clinical and on-call responsibilities.
  - The RCoA encourages College Tutors to identify those SAS grades with aptitude and to nominate them to the local School of Anaesthesia, specifying the areas in which they have appropriate expertise. SAS grades who are Fellows or Members (by examination or *ad eundem*) or Associate Fellows or Members of the RCoA, and who have been accepted by their School of Anaesthesia as trainers may, if they so wish, ask for their name to be recorded with the College as "Approved to Train".
  - The specific areas in which SAS grades train are best identified at local level, but may include specialist operating lists where a SAS grade has expertise. SAS grades who undertake training must have the opportunity to acquire the skills of a competent trainer.
  - When being trained by a SAS grade, trainees must at all times have unimpeded access to consultants for advice.

**Consultant:Trainee Ratio** The number of whole time equivalent trainees in a hospital should not normally exceed the number of whole time equivalent consultants.

### 4.3: The College Tutor<sup>15</sup>

In a given Trust Hospital, the RCoA Tutor is the Trainer who represents the RCoA. College Tutors are not expected to deliver personally all aspects of training and supervision that are listed below; the intention is that the Tutor will ensure that training is properly organised, actually happens and is accessible to the trainees.

The Tutor should act as an organiser and co-ordinator of training. Specific tasks can be delegated by the Tutor to other members of the department. The delivery of high quality training requires contributions from all consultants and not just the College Tutor although the Tutor is the prime point of contact for the trainees with the Royal College of Anaesthetists. In addition to acting as an important role model and general adviser to all trainees in anaesthesia, the responsibilities of the College Tutor include:

- organisation of teaching / training;
- organising workplace assessments;
- keeping records of the progress of trainees through competences and liaising with service rota-makers;
- examination preparation for trainees;
- professional development / career advice for trainees;
- liaison with the School of Anaesthesia and Postgraduate Dean;
- representative of the College on training matters;
- audit of clinical supervision arrangements; and
- sits on the local Specialty Training Committee

### 4.4: Workplace based learning

The proportion of time the trainee spends being directly taught in the workplace will vary throughout training depending on the trainee's seniority and the nature of the clinical work. There may be variation from week to week depending on local work patterns.

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<sup>15</sup> See also *The College Tutor - Roles and Responsibilities*, 2002

**Basic level training**

- Novice trainees and those new to the UK training programme will have continuous direct supervision until they have passed the Initial Assessment of Competency.
- More experienced trainees may have the opportunity to work without direct clinical supervision but the majority of their day time duties should include direct clinical teaching by consultants. *This does not obviate the need for appropriate educational and clinical supervision at other times.*

**Intermediate, higher and advanced level training**

- Within the limitations of local work patterns trainees carrying out general duties are normally expected to undertake a minimum of three theatre lists per week with a consultant. It is important that their programme includes consistent exposure to general anaesthesia for elective and emergency work. *This does not obviate the requirement for appropriate educational and clinical supervision at other times.*
- Trainees undertaking higher and advanced special interest training will have programmes appropriate to the needs of that special interest. In most cases this will require higher levels of clinical and educational supervision which can be reduced as the trainee gains competence.

**All trainees**

- For trainees working outside the operating theatre (eg obstetrics, ICM and pain) a minimum of 30% of their time during daytime hours should comprise direct clinical teaching. *This does not obviate the requirement for appropriate educational and clinical supervision at other times.*
- Time spent outside the operating theatre (eg ICM, pain, obstetrics) must not detract from essential training in general anaesthesia for every trainee.

**4.5: Formal education**

Every trainee must have an educational supervisor and must sign a training/learning agreement at the start of each post<sup>16</sup>.

Within the department there should be arrangements for a formal, weekly, educational, departmental meeting and for meetings to cover audit, critical incident reporting, and morbidity and mortality. Although it is accepted that not all consultants can always be present at such educational meetings, it is expected that consultants will participate whenever possible. It is expected that all trainees will participate in these formal departmental educational meetings. This time should be 'ring fenced' such that trainees are not required to cover service commitments during this period save in exceptional circumstances.

Records of attendance by all grades of anaesthetic staff at departmental educational meetings must be kept in the department. If a trainee is absent, the reason should be recorded. These records may be considered in the assessment of individual trainees.

Attending group educational activity in hospitals is part of the professionalism of good doctors. Attendance at departmental clinical meetings should be one of the forms of evidence of progress presented at appraisal and for RITAs. Local Specialty Training Committees should determine what level of participation should be mandatory for progress at the Annual Review.

Trainees must have a meeting with their educational supervisor (or a representative) at least three-monthly, to discuss their progress, outstanding learning needs and how to meet them<sup>17</sup>.

<sup>16</sup> PMETB Generic Training Standards Standard 6 dated April 2006

## 4.6: Research

### **Research**

- Research is regarded by the RCoA as integral to the development of anaesthesia, intensive care and pain management and is an obligatory part of training. Every trainee should be able to evaluate new developments in their specialty thus preparing themselves for their future career. To achieve this, trainees from ST year 3 onwards require experience in research methods so that they can:
  - learn to pose relevant research questions, formulate hypotheses, design simple research projects, understand the statistical evaluation of such projects, and how to draw valid conclusions;
  - develop and maintain a system of continuous learning in order to keep abreast of major clinical and research developments; and
  - in the context of training, learn to apply audit principles to their own work and to clinical practice.
- Some trainees however, will wish to pursue their special research interests in greater depth in their own School of Anaesthesia, elsewhere in the UK or abroad. Provided that it has the support of the Local Specialty Training Committee and the Postgraduate Dean, up to 12 months of training in ST years 5, 6 or 7 can be allocated to research for the purposes of awarding a CCT. Time in excess of this must be taken as out of programme experience and will not count towards the CCT.

## 4.7: Professionalism

Medical professionalism can be defined as a set of values, behaviours and relationships that underpin the trust the public has in doctors. Because professionalism means more than clinical competence, throughout their training all trainees are required to learn, acquire and develop professional knowledge, skills, attitudes and standards of behaviour at a level and pace commensurate with their stage of training. They can expect to be assessed regularly on this throughout their training programme. Within the context of this CCT programme professionalism is divided into two separate but over-lapping and closely related areas:

- attitudes, communication and behaviour: and
- professional knowledge and skills

The level at which professionalism should be taught, acquired and assessed at each stage of training will depend on the progress and level of training of each trainee, and the arrangements in place within individual Schools of Anaesthesia.

**Attitudes, communication, and behaviour** Problems with professional and clinical behaviour, attitudes and communication in the workplace are a major factor in the genesis of many major critical incidents and of disciplinary procedures and complaints about consultants. They are also a common cause of problems in training. Such behaviours depend in part upon the character traits of the individual but to a great extent suitable behaviour can be learned. They can also be taught, by such means as reviewing and evaluating problems, at a personal or group level.

- *Communication skills* Communication skills are developed both formally and informally, although there should be formal training in presentation skills. Inter-personal communication skills should be included in assessments provided by individual consultant supervisors and remedial training should be devised and provided to meet individual needs.

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<sup>17</sup> PMETB Generic Training Standards Standard 6 dated April 2006

- *Attitudes and behaviour* Teaching acceptable behaviour, attitudes and communication skills (or more likely rectifying short-comings in these areas) requires that acceptable standards are clearly described to the learner.
- *Assessment* Appendix E includes guidance on standards for assessing communication skills, attitudes and behaviour. The learner's behaviour must be compared with these standards and records of good and bad performance should be kept as part of the routine assessment process.

### **Professional knowledge and skills**

- It is essential for all anaesthetists and for the specialty that those taking up consultant posts should be able to play a full part in the running of the NHS. By the time trainees have completed their CCT it is expected that they will have an understanding of those areas which will form an important part in determining their maturity and suitability for taking up a consultant post. For this to happen, all trainees will need to follow a common core of training to develop their professional knowledge and skills appropriate to their stage of training, including the subjects set out in the following Appendices.
  - The Responsibilities of Professional Life (Appendix F)
  - Teaching and Medical Education (Appendix G)
  - Health Care Management (Appendix H)
  - Information Technology (Appendix I)
  - Medical Ethics and Law (Appendix J)
- What is set out in the appendices is not a syllabus but rather an indication of where attention should be directed. There is much overlap between these subjects and commonality with many of the objectives for attitudes, communication and behaviour described in Appendix E.
- *Delivery of training* Although *The CCT in Anaesthesia Parts II to IV* include indicative objectives to be achieved in each of the generic areas described above and communication skills, Schools of Anaesthesia will find their own model for achieving what is set out in Appendices E to J. For some aspects, trainees may take study leave and attend a specific course; for example this has long been a recognised method for learning about health care management. Much can be achieved by taking advantage of what is available locally, for instance School based courses bringing in clinical and non-clinical managers to talk or attachments for trainees with individual managers have both been used successfully. Whichever way the training is delivered records of achievement must be maintained as part of the trainee's portfolio for presentation at the annual appraisal and for the RITA.

**Team working and leadership** Anaesthetists have to work as part of a wider team and are expected to demonstrate leadership. Formal training in these areas is not built into this curriculum, but the absence of these qualities should be commented on in workplace based assessments and discussed at appraisals. Remedial training should be devised and provided to meet individual needs.

### **Equality and Diversity**

- The RCoA conforms to the view that equality of opportunity is fundamental to the selection, training and assessment of anaesthetists. It seeks to recruit trainees regardless of race, religion, ethnic origin, disability, age, gender or sexual orientation. Patients, trainees and trainers and all others amongst whom interactions occur in the practice of anaesthesia have a right to be treated with fairness and transparency in all circumstances and at all times. Equality characterises a society in which everyone has the opportunity to fulfil his or her potential. Diversity addresses the recognition and valuation of the differences between and amongst individuals. Promoting equality and valuing diversity are central to the anaesthesia curriculum. Discrimination, harassment or victimisation of any of these groups of people may be related to: ability, age, bodily appearance and decoration, class, creed, caste, culture, gender, health status,

relationship status, mental health, offending background, place of origin, political beliefs, race, and responsibility for dependants, religion and sexual orientation.

- The importance of Equality and Diversity in the NHS has been addressed by the Department of Health in England in 'The Vital Connection'<sup>18</sup>, in Scotland in 'Our National Health: A Plan for Action, A Plan for Change'<sup>19</sup> and in Wales by the establishment of the NHS Wales Equality Unit. These themes must therefore be considered an integral part of the NHS commitment to patients and employees alike. The theme was developed in the particular instance of the medical workforce in 'Sharing the Challenge, Sharing the Benefits – Equality and Diversity in the Medical Workforce'<sup>20</sup>. Furthermore, Equality and Diversity are enshrined in legislation enacted in both the United Kingdom and the European Union. Prominent among the relevant items of legislation are:
  - Equal Pay Act 1970
  - Sex Discrimination Acts 1975 and 1986
  - Indirect Discrimination and Burden of Proof Regulations 2001
  - Race Relations Act 1976 and Race Relations (Amendment) Act 2000
  - Disability Discrimination Act 1995
  - Employment Rights Act 1996
  - Human Rights Act 1998
  - Employment Relations Act 1999
  - Maternity and Paternity Leave Regulations 1999
  - Part Time Workers Regulations 2000
  - Employment Act 2002
  - European Union Employment Directive and European Union Race and Ethnic Origin Directive
  - Age Discrimination Act 2006
- It is therefore considered essential that all persons involved in the management of training (Board, Tutors, Training Programme Directors et al) are trained and well versed in the tenets of Equality and Diversity and it is expected that all trainers should be trained in Equality and Diversity.
- As part of their professional development trainees will be expected to receive appropriate training in equality and diversity to the standards specified by PMETB<sup>21</sup> and to apply those principles to every aspect of all their relationships. The delivery of this training is the responsibility of the Postgraduate Dean. A record of completion of this training must be held in the trainee's portfolio. The benefits of this training are:
  - To educate the trainee in the issues in relation to patients, carers and colleagues and others whom they may meet in a professional context
  - To inform the trainee of his or her reasonable expectations from the training programme
  - To advise what redress may be available if the principles of the legislation are breached

**Child protection** The *Children Act 1989* is the legislative authority for child welfare and protecting children from abuse. Sections 27 and 47 of Act place duties on various agencies to assist social services departments in actual or suspected cases of child abuse. Detailed requirements for the knowledge, skills and attitudes required of anaesthetists at all levels of their training are detailed in the paediatric anaesthesia sections of *The CCT in Anaesthesia Part II Appendix 3*, *The CCT in Anaesthesia Part III Appendix 1* and *The CCT in Anaesthesia Part IV Appendices 1 and 2*.

<sup>18</sup> The Vital Connection: An Equalities Framework for the NHS: DH, April 2000

<sup>19</sup> Our National Health: A Plan for Action, A Plan for Change: Scottish Executive, undated

<sup>20</sup> Sharing the Challenge, Sharing the Benefits – Equality and Diversity in the Medical Workforce: DH Workforce Directorate June 2004.

<sup>21</sup> PMETB *Generic Standards for Training* dated April 2006

#### 4.8: Training accommodation

Any hospital with trainees must have appropriate accommodation to support their training and education; this may be in the anaesthetic department or elsewhere in the hospital eg the Postgraduate Teaching Centre. This accommodation should include:

- a focal point for the anaesthetic staff so that effective service and training can be co-ordinated and optimal opportunities provided for gaining experience and teaching;
- adequate accommodation for trainers and teachers in which to prepare their work;
- a private area where confidential activities such as assessment, appraisal, counselling and mentoring can occur;
- a secure storage facility for confidential training records;
- a reference library where trainees have ready access to bench books (or an electronic equivalent) and where they can access information at any time;
- access for trainees to IT equipment such that they can carry out basic tasks on a computer including the preparation of audio-visual presentations. Access to the internet is recognised as an essential adjunct to learning;
- a suitably equipped teaching area; and
- a private study area.
- an appropriate rest area whilst on call

#### 4.9: Equipment guidance

From time to time the College will issue guidance or instructions on the use of equipment by trainees. These will be prompted by safety requirements, often arising from critical incidents, and will normally be promulgated by immediately by e mail or letter to all Regional Advisors and College Tutors, and then included in the next edition of *Guidance for Trainers*. The following requirements currently exist:

**Capnography** Trainees should not be required to deliver anaesthesia without using monitoring equipment which complies with the recommended minimum monitoring standard current at that time. When a trainee is intubating the trachea during induction of anaesthesia or managing an intubated patient during anaesthesia, a capnograph *must* be used as part of the monitoring procedure. .

- No trainee should be put into the position of having to intubate the trachea without a capnograph being available. If a capnograph is not available, either the patient or the equipment should be moved.
- Trainees should not be required to deliver general anaesthesia without the availability of monitoring equipment, including capnography, which complies with the recommended minimum monitoring standards as defined in:
  - *Recommendations for Standards of Monitoring during Anaesthesia and Recovery*, Revised Edition 1994, Association of Anaesthetists
  - *Good Practice, a Guide for Departments of Anaesthesia*, 1998, Royal College of Anaesthetists and the Association of Anaesthetists

#### **Capnography for ICM**

All trainees intubating or reintubating the trachea of a patient on an intensive care unit must confirm the tube position with capnography.

#### **Anti-hypoxic links**

- All anaesthesia machines must be checked before use. If appropriate for the machine the algorithm published by the AAGBI is recommended.

- Where an anaesthetic machine is being used it is mandatory for trainees to work with equipment that has a tested oxygen analyser in the common gas outflow or breathing system. The oxygen analyser must possess a low concentration alarm which is active.
- Trainees must not administer nitrous oxide from an anaesthetic machine that does not have an anti-hypoxia linkage between the oxygen and nitrous oxide flow controls.

## 5: PRINCIPLES OF CLINICAL SUPERVISION

The definitions of supervision described below, have been developed from a consideration of the professional responsibilities of medical practitioners to patients.

### 5.1: Clinical supervision: the obligation to patients

Every patient undergoing anaesthesia (including pre and post-operative care), intensive care and pain management is cared for under the direction of an appropriate named consultant. On some occasions consultants will themselves carry out the clinical aspects of the work; on other occasions, when appropriate, it can be delegated to a trainee or a SAS grade doctor. To ensure the safety of patients, however, a trainee must be responsible to, and subject to clinical supervision by, a designated consultant *at all times*. This includes those occasions during elective, urgent and emergency work when the trainee, as part of their training, is delegated the authority to make decisions without immediate reference to a more senior clinician.

Trainees must be encouraged to seek advice and/or assistance as early as possible whenever they are concerned about patient management. This applies both in and out of hours. At all stages of training, a supervisor must respond with appropriate support to a request for assistance from a trainee. *Patient safety must never be compromised.*

Every doctor should be prepared and able to oversee the work of less experienced colleagues and must make sure that medical and dental students and qualified doctors in training are properly supervised.<sup>22</sup>

### 5.2: Grades of clinical supervision

Clinical supervision of daytime and out of hours duties for anaesthesia (including pre and post-operative care), intensive care and pain relief falls into two categories: *direct* and *indirect*.

**Direct supervision** This means the trainee is working directly with a supervisor senior to themselves who is actually with the trainee or can be present within seconds. This proximity maintains patient safety but when appropriate allows a trainee to work with a degree of independence in order to develop confidence.

**Indirect supervision** Indirect supervision falls into two categories: *local* and *distant*.

- **Local supervision** This means that the supervisor *is on the same geographical site*, is immediately available for advice and is able to be with the trainee within 10 minutes of being called. The actual permitted time (which may be less than 10 minutes) and/or distance separation of the supervisor from the trainee (e.g. in a nearby theatre with another trainee, doing administrative tasks, on the ICU, in a meeting etc.) should be determined locally to maintain acceptable levels of patient safety and will depend on the combination of the trainee's grade, the nature of the clinical work and the layout of the hospital.
- **Distant supervision** This means the supervisor is available rapidly for advice but is off the hospital site and/or separated from the trainee by over 10 minutes. The maximum time or distance separation permitted will depend upon the combination of the trainee's grade, the nature of the clinical work, local geography and traffic conditions. Since this is a quality of care, patient safety and risk management issue, the details should be determined in individual cases by the Clinical Director. Frequently used guidelines are

<sup>22</sup> *Good medical practice*, GMC 1998, paragraph 10: *The doctor as teacher*, GMC 1999, paragraph 5.

consultant availability on site within 30 minutes or a travelling distance of less than 10 miles. Support for trainees during distant supervision is one of the factors considered when recommending to the Deanery and PMETB the grade and number of trainees who can be trained at any given hospital. Distant supervision requires that:

- the trainee and supervisor agree that it is appropriate for the trainee;
- the trainee knows the limitations within which he/she can work; and
- the trainee is capable of managing the possible complications of any procedure he/she might reasonably be expected to undertake until help arrives.

### **5.3 Clinical supervision by consultants**

All operating lists involving a trainee, as well as regular sessions in obstetrics, intensive care medicine, pain management and radiology, should be allocated to a named consultant or SAS grade doctor. It is accepted that absences (holiday, study leave, professional leave or sickness) will occur. However, when such absences occur and a trainee undertakes a list, there must be an arrangement to provide direct or indirect (as appropriate) consultant supervision for the trainee e.g. the “starred consultant” system.

### **5.4: Clinical supervision by SAS grades**

When clinical supervision of a trainee is being provided by a SAS grade doctor, the trainee must always have unimpeded access to a consultant.

### **5.5: Clinical supervision of one trainee by another**

Clinical supervision of one trainee by another occurs, and senior trainees must learn how to do this safely. A junior trainee may refer to a more senior trainee as their first line of advice and assistance. However, both trainees must be subject to supervision from a designated consultant.

There will be some occasions during highly specialised training when it will be inappropriate for senior trainees to act as supervisors as they themselves may then require direct supervision from a consultant.

### **5.6: Clinical supervision in remote sites**

The RCoA defines a remote site as any location where general or regional anaesthesia is administered away from the main theatre suite and/or anaesthetic department and in which it cannot be guaranteed that the help of another anaesthetist will be available within 5 minutes of being requested. This may be either within or away from the base hospital. The relative isolation may be created by horizontal (eg corridors and roads) or vertical (eg stairs and lift) separation, by locked doors, local traffic conditions or by a combination of factors.

Trainee anaesthetists should be permitted to work in a remote site only if:

- the trainee is judged by the Clinical Director or other responsible consultant to possess knowledge and experience which is appropriate to undertaking such duties;
- a consultant is available to provide advice or help for the trainee throughout the period that the trainee is anaesthetising in a remote site;
- skilled assistance for the trainee anaesthetist is available in the remote site at all times;
- the anaesthetic equipment and monitoring complies with the current recommended guidelines and standards appropriate to the work being performed in the remote site; and
- the trainee is prepared to do so.

## **5.7: Clinical Teaching**

The placement of a trainee with a consultant is always a teaching opportunity even if it is primarily required to provide clinical supervision for patient safety. Consultants must work with trainees both to teach them and to assess their competence on a daily basis. The RCoA believes that the time spent by trainees working directly with consultants should be as specified in Section 4.5. This experience is best described as clinical teaching to distinguish it from pairings that occur for reasons of safety (clinical supervision) though all direct clinical supervision is also clinical teaching.

## 6: APPRAISAL, ASSESSMENT AND REVIEW

### 6.1: Definitions

The RCoA regards the regular appraisal, assessment and review of trainees as an integral part of the postgraduate educational process. It is also a non-negotiable requirement for all doctors employed by the NHS and for re-validation with the GMC.<sup>23</sup> The three parts of the process are:

**Appraisal** Appraisal of trainees is intended:

- to provide constructive dialogue that will identify, anticipate and lead to action on the strengths and weaknesses in a trainee's performance;
- to review educational targets
- to review the results of any assessments or examinations
- to provide provisional feedback and support towards progress
- to meet the NHS requirement for the annual appraisal of all employees;
- to facilitate the production of a personal development plan; and
- to provide evidence for GMC re-validation.

**Assessment** The purpose of assessment is to:

- *Determine fitness for professional practice* This means more than the performance of clinical skills, no matter how complex. Very importantly it carries an in-built commitment to standards, and the attitudes which will maintain those standards throughout professional life.
- *Provide evidence of competence in a trainee* This is to confirm the possession of the appropriate knowledge, skills and attitudes required to undertake safe clinical practice at a level commensurate with their level of training.
- *Provide evidence of confidence and competence in a consultant* This is to confirm the possession of the confidence, knowledge, skills and attitudes necessary for independent professional practice.

#### **Record of In-training Assessment (RITA)**

The RITA is not in itself an assessment or review, it is a procedure for recording the assessments which form a regular part of every trainees' programme. As such it provides a record of a trainee's progress through his/her training programme. The trainee and the postgraduate dean or his staff should complete and sign a RITA each year.

#### **Annual Review**

- The aim of the Annual Review of the RITA is to bring together all aspects of training to produce a composite picture and record of the trainee's achievements, shortcomings and future training needs.
- The Annual Review consists of two parts:
  - a formal review of evidence in the trainee portfolio leading to a judgement on the trainee's progression, and
  - an educational appraisal concerning the planning of further progression or any remedial action required. This should be conducted by heads of training programmes and their designated deputies.

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<sup>23</sup> *A License to Practise and Revalidation*, GMC April 2003

## 6.2: Basic principles

Appraisals and assessments should be conducted regularly.

No judgement or decision made at an *Annual Review* should come as a surprise to the trainee. The obvious opportunity for immediate relevant feedback on problems or difficulties is in the workplace, i.e. any weakness in performance, should already have been identified, discussed and recorded at an *appraisal* or as part of an *assessment*.

## 6.3: Anaesthetic non-Technical Skills (ANTS)

ANTS was developed by a team of Scottish anaesthetists working with the Department of Industrial Psychology at Aberdeen University. It was designed to provide an assessment tool for tutors and supervisors, based upon a cognitive task analysis of the working practices of anaesthetists. ANTS relies upon the systematic observation of real work and the focus is:

- to develop a culture of safety in anaesthetic education;
- to place non-technical skills on the curriculum;
- to be formative;
- to be diagnostic; and
- to contribute to overall summative assessments.

Subsequent trials with trainers and trainees have shown that ANTS has the potential to give the insight necessary to improve their performance as assessors, appraisers and trainees. The College is considering how the ANTS methodology may be best incorporated into anaesthetic workplace based assessment and appraisals, and will be issuing further recommendations. Meanwhile, appraisers, assessors and trainees should familiarise themselves with the principles of ANTS and trainees should record this fact in their Personal Portfolio.

## 6.4: Appraisal

***Principle of appraisal*** Appraisal is not the same as assessment. Appraisal is a confidential process, usually with the trainee's educational adviser, which provides through constructive and *regular* dialogue, two-way feedback on a trainee's performance and advice on career progression.

### ***Frequency of appraisal***

- ***Annual appraisal*** At least one appraisal must occur each year to support the Annual Review, NHS personnel policy and GMC re-validation. This mandatory annual appraisal should take place sufficiently in advance of the Annual Review to allow the trainee and trainers to organise any measures agreed at appraisal that may affect the outcome of the Annual Review. A fresh appraisal must precede each Annual Review.
- ***Other appraisals*** Other appraisals may occur as and when needed eg on arrival at a new hospital, to review progress after specialist attachments and following the Annual Review.

### ***Appraisal documentation***

- ***Input*** Appraisals must include a review of the trainee's Professional Portfolio. The portfolio should include all the documentation supporting every assessment that has been made during the period of training under consideration.
- ***Output*** Although appraisal discussions are confidential and should not be used to inform any assessment, a simple factual record that the appraisal occurred and of agreed outcomes, including a Personal Development Plan (PDP), must be made and signed by the appraiser and trainee. This may be used, with the agreement of the trainee and the

appraiser to inform the Annual Review and GMC re-validation. *If the outcome of a PDP cannot be agreed this must be recorded as a matter of fact.*

## 6.5: Assessment of clinical skills

**Principles of assessment** Regular assessment in the workplace provides both the trainer and trainee with a picture of the trainee's progress towards the expected competences appropriate to his/her level of training. Assessment will take place both in the workplace and by examination.

- Clinical assessment is an essential professional requirement, which should be done well but with the minimum of disruption to clinical activity.
- Knowledge, skills and attitudes should all be assessed..
- Progression in training will depend upon the successful acquisition of mandatory competences.
- If the trainee fails to attain the necessary standard he/she needs to know why and must have the right of appeal.
- Trainers must be as honest and objective as possible when assessing trainees, otherwise not only is process fundamentally flawed, but patients may be put at risk<sup>24</sup>.
- Trainees unsuitable for the specialty should be identified as soon as possible; preferably before the end of the first year of training. How this is done for is described in *The CCT in Anaesthesia II: Basic Level Training and Assessment* Section 2.
- As the trainee moves through the training programme, the emphasis placed on the triad of knowledge, skills and attitudes will gradually change, moving from well defined, predominantly skill and knowledge based measures during basic level training to wider professionally based measures in the latter stages of higher and advanced level training eg decision making, the expanding professional role and reflective behaviour.
- Within their hospitals College Tutors are responsible for co-ordinating the assessments and monitoring trainees' progress but they are not expected to perform all formal assessments themselves. College Tutors will require the assistance of their colleagues to ensure that fair and wide-ranging assessments of the capabilities of trainees are made.
- The results of *all* assessments should be kept up to date both by trainers and by trainees in their portfolios. The portfolios, together with assessment results, will be used both for appraisal and for the Annual Review.

**Key stages in assessment** The key assessment stages determining progression through anaesthetic training are:

- *Initial Assessment of Competency* Before any trainee can work without direct supervision they must pass the Initial Assessment of Competency. This is normally given after four months of basic training.
- *Mandatory assessments for obstetric and regional anaesthesia* Trainees must pass the mandatory assessments for obstetric and regional anaesthesia before being allowed to use the relevant techniques in the absence of direct clinical supervision. These normally occur during the second year of basic level training.
- *Basic Level Training Certificate (BLTC)* Before progressing to intermediate level training a trainee must have passed the necessary Workplace Assessments to obtain a BLTC as defined in *The CCT in Anaesthesia II: Basic Level Training and Assessment*, including passing an assessment of knowledge i.e. the Primary FRCA Examination or an exempting qualification.
- *Annual Review* Evidence of the quality, quantity and variety of work will be reviewed annually and a decision regarding further progress and training needs will be made. Local Specialty Training Committees will use a variety of criteria for making decisions on

<sup>24</sup> *The doctor as teacher*, GMC 1999, paragraph 7

progress. These might include satisfactory completion of special interest training, attendance at teaching events or doing an audit project. Where schools choose to make such things mandatory parts of the local Annual Review they must:

- publish full information of what is expected of trainees;
- secure the agreement of their Postgraduate Dean; and
- secure the agreement of the RCoA Training Committee.
- **Intermediate Level Training Certificate** For progress to higher level training a trainee must have passed the necessary Workplace Assessments defined in *The CCT in Anaesthesia III: Intermediate Level Training and Assessment*, including passing an assessment of knowledge i.e. the Final FRCA Examination or an exempting qualification.
- **CCT** The award of a CCT will be recommended when the assessments for higher and advanced level training have been satisfactorily completed. All higher and advanced level assessments will be hospital based. The award of a CCT will not depend on success in the examinations of any examining body taken during higher and advanced years of training.

### **Frequency of assessment**

- **Routine**
  - The RCoA is not prescriptive about the frequency of clinical assessment for individual units of training provided that assessment is done throughout training and that at the end of each unit of training there is evidence that the trainee has achieved the necessary competences. Each trainee should keep a record of any evaluations in their portfolio and produce them at the end of each stage of training, at appraisals and for the Annual Review.
  - The College will review guidance on this subject in the light of experience.
- **Moving hospital** Before a trainee moves to another hospital appropriate assessments should be completed.

### **Clinical assessment tools**

Following the introduction of Foundation Year training and a study of assessment techniques, the RCoA has decided that common tools and documentation should be used for workplace based assessment, unless other formats are explicitly required e.g. *The Initial Assessment of Competency*. The College is not prescriptive about which tools should be used for each unit of training, but will review guidance on this matter in the light of experience. The tools to be used are: Direct Observation of Procedural Skills, Mini-Clinical Assessment Evaluation Exercise and Case Based Discussions. Any or all of these assessments may be backed up by the trainee conducting a parallel self-evaluation.

- **Direct Observation of Procedural Skills (DOPS)**
  - The DOPS assessment takes the form of the trainee performing a specific practical procedure that is directly observed and scored by a consultant observer, using the structured form at Appendix K. Performing a DOPS assessment will slow down the procedure but the principal burden is providing an assessor at the time that a skilled trainee will be performing a practical task.
  - Being a practical specialty there are numerous examples of procedures that require assessment as detailed in each unit of training. The assessment of each procedure should focus on the *whole event*, not simply, for example, the successful insertion of cannula, the location of epidural space or central venous access such that, in the assessors' judgment the trainee is competent to perform the individual procedure without direct supervision.
- **Mini-Clinical Assessment Evaluation Exercise (mini-CEX)**
  - The key learning event in anaesthetic training is the supervised operating list, where management plans are formulated, problems are discussed, techniques and procedures taught and behaviours learnt. Therefore an operating list, obstetric emergency or ICU admission is too valuable an opportunity to miss, and so should be

fully exploited for occasional use in trainee assessment. The mini-CEX is intended to evaluate the core skills that trainees employ in many clinical scenarios throughout the curriculum.

- In practice, this assessment should be undertaken at the trainee's behest, in a routine operating list undertaken with a consultant or senior trainee (ST years 6 and 7). The assessor will act primarily as an observer and allow the trainee to manage the major part of the list. The assessor will stimulate dialogue – not in an attempt to gauge depth of knowledge – but more to understand thought processes and management decisions made through the course of a procedure or list. Feedback and discussion at the end of the session is mandatory. The assessor then scores the trainee in each of the seven domains described below, using a standard form (Appendix L).

Domain	Descriptor
Pre-op assessment	Appropriate questions, focuses questions and physical exam on areas of concern / relevance
Patient safety	Consent, pt. Identity, machine checks, blood products, personal (gloves & masks, etc.), sidedness, sterile technique, sharps, drug labels, electrical, etc.
Professionalism	Respect, compassion, empathy, ethical, aware of own limitations
Clinical judgement	Use of appropriate technique, sound management of anaesthesia
Communication and generic skills	Patients, medical and non-medical staff
Organisation and efficiency	Organisation, preparation, makes efficient use time, anticipation
Overall clinical care	Synthesis of above, effective

- **Case-based Discussion (CbD)**

- Case-based discussion is designed to evaluate trainee clinical practice, decision-making and the interpretation and application of evidence, by reviewing their record of anaesthetic practice. Its primary purpose is to enable a conversation between trainee and assessor about the presentation and anaesthetic management of a patient. It is not intended as a test of knowledge, nor as an oral or clinical examination. It is intended to assess the clinical decision-making process and the way in which the trainee used medical knowledge when managing a single case. Trainers are always evaluating the clinical practice and clinical management skills of their trainees subjectively and this tool is a way of formalising that process
- CbD is useful throughout training and especially as a basis for discussion of complications that may have occurred where the trainee was not directly supervised by a consultant. Another example is for discussion of rare events that may not have occurred during the trainee's attachment such as eclampsia in obstetric anaesthesia, air embolism in neurosurgical or cardiac anaesthesia, total spinal block in regional anaesthesia, epiglottitis in paediatric anaesthesia. Such discussions may also incorporate an assessment of the adequacy of a trainee's record keeping, although this is not the primary purpose of CbD.
- In practical terms, the trainee will arrange a CbD with an assessor (Consultant or Senior trainee) and bring along a selection of three anaesthetic records from cases in which he/she has recently been solely involved. The assessor selects one and then engages the trainee in a discussion around the pre-operative assessment of the patient, the choices and reasons for selection of techniques and the management decisions with to respect pre-, intra- and post-operative management. The assessor then scores the trainee in each of the seven domains described below, using a standard form (Appendix M).

Domain	Descriptor
Anaesthesia record, drug and IV chart	Complete, signed, legible, dated, appropriate
Pre-op assessment and review of investigations	Implication for anaesthetic management
Choice of anaesthetic technique	Reasoning, alternatives, risks and benefits
Anaesthetic management	Intra-op management decisions, incidents

Post-op care	Analgesia, fluids, post-op instructions - alternatives
Professionalism	Self evident
Overall clinical care	Self evident

- It may be appropriate only to score 3 or 4 domains at a single event, and it should be emphasised that the purpose of the tool is to understand the decision processes and thinking of the trainee. CbD is the trainee's chance to have somebody pay close attention to an aspect of their clinical thinking and to provide feedback. Feedback and discussion is mandatory.
- **Self evaluation** It may be helpful to ask the trainee to complete an evaluation form before any assessment, in order to gauge insight. The form would be identical to that used by the assessor. This may also be usefully done at the beginning and end of a 'module' to see how the trainee's evaluation of his / her own ability evolves.

## 6.6: Assessment of knowledge

Knowledge is tested informally on a day-to-day basis in the operating theatre, on the ward, in the ICU and in the pain clinic. Relevant knowledge should form part of routine clinical assessment in the workplace i.e. does the trainee have an adequate knowledge base to support the decisions he/she makes? The trainee's ability to demonstrate appropriate knowledge should be included in any written assessment.

The RCoA formally assesses the trainee's knowledge base through either the FRCA Primary and Final Examinations or a prospectively approved equivalent qualification. Each examination, when passed, indicates that the trainee has sufficient knowledge of basic sciences and clinical anaesthesia to underpin a particular level of safe clinical practice. The Final Examination is a basic standard of knowledge that is expected of all trainees, irrespective of their ultimate branch of anaesthesia.

More details of assessments by examination for each stage of training can be found in *The CCT in Anaesthesia Parts II and III*.

## 6.7: Assessments of professionalism, attitudes and behaviour

- In the specialty of anaesthesia aspects of personality and lifestyle e.g. unavailability at short notice when on call, persistent lateness wasting theatre time, attitudes that recurrently produce conflict in the working environment, are just as important to patient care as the ability to understand key aspects of pharmacology or monitoring.
- Acceptable attitudes and behaviour should be inculcated from the beginning of training in anaesthesia and are assessed in three ways:
  - firstly and continuously as skills in their own right, with feedback on deficiencies needing to be rectified;
  - secondly as objectives integral to individual units of training. The latter objectives can be found in individual sections of *The CCT in Anaesthesia Parts II, III and IV*; and
  - thirdly, at least once per year there must be a formal assessment of attitudes and behaviour; any problems identified must be discussed with the trainee.
- Assessing professionalism, attitudes and behaviour is the most difficult and subjective part of the assessment process because every trainee will be different. To be effective assessment of attitudes and behaviour often requires moral courage by the assessor to point out, and a degree of insight and humility by the trainee to accept, what may be deeply ingrained character traits. Thus although attitudes and behaviour are formally recorded as part of the assessment process, the identification of problems and their solution may best be handled within regular, confidential appraisals.

- Discussion of issues of professionalism, attitudes and behaviour should be based upon objective evidence such as the results of formal Multi-Source Feedback (MSF) assessments, and may include both compliments, and complaints (formal or informal). Discussion may also arise from consideration of the in-training assessments by consultants. Where an assessor believes that they have discovered a problem they should produce a timely and full report with their assessment form. This should describe exactly what happened, why it was an example of poor performance, the time and date and the names of any other witnesses. In order to act upon reports of unsatisfactory performance developing from problems with the affective issues of practice there must be a weight of fully documented evidence of habitual problems. The number of episodes that constitute a serious problem requiring action will depend on their severity.
- The RCoA accepts the University of Aberdeen's Anaesthetic non-Technical Skills assessment package, described in Section 6.3, as a particularly useful philosophy for all assessments but particularly for assessments of professionalism, attitude and behaviour.
- Failure to keep a record of the evidence and to deal with matters when they occur, (thereby allowing poor practice to be seen as acceptable), may result in an appeal against the Annual Review or an individual assessment.

### ***Frequency of assessment***

An assessment dedicated to attitudes and behaviour should be carried out at least annually. A format for obtaining feedback from medical colleagues is given as an example in Appendix E. In due course central guidance and or direction on this may be given by the PMETB e.g by the introduction of a nationally validated system of Multisource Feedback (MSF).

### ***Multi-Source Feedback (MSF)***

A number of tools exist to examine behaviour. They mostly rely on feedback ratings obtained from colleagues and/or patients. All require a considerable commitment of time and resources if they are to be done fairly and safely. If not done properly, with appropriate collation of evidence and the provision of careful and sensitive feedback, they can be devastating to trainees.

Until such time that central direction and or guidance is available the RCoA recommends that trainers and trainees who want to use MSF as an assessment tool should use Team Assessment of Behaviour (TAB) which with only 4 domains and a 3 point rating scale is straightforward and feasible. An example of TAB is at Appendix N

## **6.8: Annual Review of the RITA**

The Annual Review of the RITA is the process whereby all aspects of a trainee's work throughout the year come together for review at Deanery level to be deemed satisfactory or otherwise.

The Annual Review is divided into two parts:

- The first part is a formal consideration of a trainee's portfolio including the results of all assessments which have been carried out, by a panel including the PG Dean or his representatives. A formal judgment on the trainee's progress will then be made. This part of the process may be paper based, without the presence of the trainee.
- The second part of the process is an educational appraisal, for which the trainee must be present. This concerns the planning of further progression or any remedial action required, and should be conducted by heads of training programmes and their designated deputies.

At the end of the process the appropriate RITA form will be issued.

The RCoA works with the Postgraduate Deans to conduct the Annual Review to provide a composite picture of the trainee's achievements, shortcomings and future training needs.

The trainee must have received an appraisal since their previous Annual Review. The Annual Review should take into account assessments, examination results, log book records, courses attended and audit and research reports. COPMeD's policy on implementing RITA's can be found at Appendix O.

**Evidence Presented for the Annual Review** Evidence of progress presented to the Annual Review must include everything related to the particular stage of training. The RITA G at the end of training must include an evaluation of training in all areas. Evidence for the Annual Review should include, as appropriate:

- Copies of previous RITA forms.
- The trainee's logbook.
- Evidence of completion of the appropriate mandatory experience for the year.
- The trainee's portfolio of learning.
- The trainee's performance in formal RCoA assessments.
- The trainee's performance in professional examinations.
- The summary of the trainee's most recent Annual Appraisal and Personal Development Plan.
- The workplace assessment reports of trainers.
- Evidence of participation in clinical audit.
- Evidence of participation in departmental education and clinical meetings.
- Evidence of training in research.
- Evidence of training in management.
- Evidence of learning to teach.
- Records of formal training in eg ATLS, ALS, PALS and simulator experience.
- Any other information decided upon locally.

## 6.9: The trainee in difficulty

For the great majority of trainees the annual reviews will confirm that they are on course to complete training. For those who do not progress as expected additional help and support must be given to enable them to fulfil the requirements of the programme. The need for any additional help should become apparent at an early stage through the normal appraisal process. Help might involve extra supervision, counselling or specially focused training. Those involved in the annual review should also take account of any relevant external factors put forward by the trainee which may have affected progress in training.

Trainees should be aware that the outcome of meetings with their supervising consultants or educational supervisors may exceptionally, with their knowledge, inform the assessment process and may be included in the annual review. Such information should be recorded.

Where, as a result of an annual review, progress is not judged satisfactory there are three levels or stages of action that may follow; more information can be found in the "Gold Guide":

- **A recommendation for targeted training.** This involves closer than usual monitoring and supervision and should provide specific training experiences to address particular needs and a more regular feedback on progress. Targeted training will not usually mean that progress in the grade will be delayed.
- **A recommendation for intensified supervision or repeat experience.** Normally, but not necessarily, this will happen if targeted training proved unsuccessful. The annual review panel might consider that, after discussion with the trainee, it is necessary for the trainee to repeat a section of the programme. This could be at another location if this was beneficial. A key principle of effective supervision is that it depends on openness and a shared knowledge of problems; therefore the Deanery programme director will have discretion to decide how far the trainee's problems are shared with a new trainer.
- **Withdrawal from the programme.** On rare occasions when formal and informal action have not succeeded in helping a trainee to reach a satisfactory standard and it is clear

that there is no reasonable prospect of achieving this it may be necessary to withdraw the trainee from the programme . This process should involve support and counselling to ensure that appropriate career choices are made. Timely and full documentation of the reasons leading to this decision must be maintained to defend any appeal.

### **6.10: The documentation of training**

It is essential that trainees and Schools of Anaesthesia maintain proper training records: to ensure that individual trainees receive an appropriately balanced programme of training; to inform the Annual Appraisal and the Annual Review; to support the revalidation process; and to assist the external quality control and assessment of training by PMETB, the Postgraduate Deans and the College.

#### ***The trainee's responsibilities***

- At the commencement of CCT training programme the trainee should create a Professional Portfolio into which he/she places all documentation relevant to training, including details of assessments completed and records of appraisals. This should be maintained throughout training.
- The RCoA's requirements for the maintenance of logbooks and other records, including a Professional Portfolio, are set out in Appendix P.
- It is the trainees' responsibility to ensure that their 'Workplace Assessments' for individual units of training take place *by reminding those responsible at the appropriate time*: it is not the trainer's role to chase the trainee. If however a trainee experiences unreasonable difficulty in arranging the necessary assessment they should communicate this to the College Tutor or, exceptionally, to the Regional Adviser.

#### ***The School's responsibilities***

- Details of assessments and records of appraisals must be kept by the School of Anaesthesia.
- *Retention of records* The College recommends that individual training records should be retained within Schools/ Departments for at least 3 years after a CCT has been awarded. The College retains records for 7 years after the CCT date.

**APPENDIX A:****COMMONLY USED ABBREVIATIONS**

2D – Two dimensional  
 AAGBI – Association of Anaesthetists of Great Britain and Ireland  
 ABC – Airway, breathing, circulation  
 ACA – Association of Cardiothoracic Anaesthetists  
 A&E – Accident and Emergency  
 ALS – Advanced life support  
 APA – Association of Paediatric Anaesthetists  
 APH – Ante-partum haemorrhage  
 ASA – American Society of Anaesthesiologists  
 ATLS – Advanced Trauma Life Support  
 BLS- Basic life support  
 BMA – British Medical Association  
 BP – Blood pressure  
 Ca<sup>++</sup> – Calcium ions  
 CARCSI – College of Anaesthetists: Royal College of Surgeons in Ireland  
 CAT – Computerised axial tomography  
 CCSC – Central Consultants and Specialists Committee  
 CCT – Certificate of Completion of Training  
 CEMD – Confidential Enquiries into Maternal Deaths  
 CEPD – Continuing education and professional development  
 CESDI – Confidential Enquiries into Stillbirths and Deaths in Infancy  
 CHI – Commission for Health Improvement  
 Cl<sup>-</sup> – Chloride ions  
 CNORIS – Clinical Risk and Other Risks Indemnity Scheme  
 CNST – Clinical Negligence Scheme for Trusts  
 CO<sub>2</sub> – Carbon dioxide  
 CPD – Continuing professional development  
 CPR – Cardiopulmonary resuscitation  
 CT – College Tutor  
 CTG – Cardiotocography  
 CVA – Cerebrovascular accident  
 CVP – Central venous pressure  
 DH – Department of Health  
 ECG – Electro cardiogram  
 ECMO – Extra-corporeal membrane oxygenation  
 EEA – European Economic Area  
 EEG – Electroencephalogram  
 EMD – Electromechanical dissociation  
 EMG – Electromyogram  
 ENT – Ear nose and throat  
 EPR – Electronic patient record  
 ET – Endotracheal  
 FBC – Full blood count  
 FRCA – Fellow of the Royal College of Anaesthetists  
 FTSTA – Fixed Term Specialty Training Appointment  
 FTTA – Fixed term training appointment  
 GCS – Glasgow coma score  
 GIT – Gastro-intestinal tract  
 GMC – General Medical Council (of the UK)  
 H<sub>2</sub> receptor – Histamine type 2 receptor  
 HC – Healthcare Commission  
 HCO<sub>3</sub><sup>-</sup> Bicarbonate ions

HDU – High dependency unit  
HIV – Human immunodeficiency virus  
IASP – International Association for the Study of Pain  
IBTICM – Inter-Collegiate Board for Training in Intensive Care Medicine  
ICM – Intensive Care Medicine  
ICS – Intensive Care Society  
ICU – Intensive Care Unit  
IHD – Ischaemic heart disease  
IPPV – Intermittent positive pressure ventilation  
IM – Intramuscular  
IM&T – Information Management and Technology  
IV – Intravenous  
IVRA - Intravenous regional anaesthesia  
K<sup>+</sup> – Potassium ions  
LAS – Locum appointment for service  
LAT – Locum appointment for training  
LMA – Laryngeal mask airway  
LVF – Left ventricular failure  
MAC – Medical advisory committee  
Mg<sup>++</sup> – Magnesium ions  
MmHg – millimetres of mercury  
MRSA – Methicillin resistant staphylococcus aureus  
MOE&T – Major Obstetric Emergencies and Trauma  
MOSES – Multidisciplinary Obstetric Simulated Emergency Scenarios  
MRI – Magnetic resonance imaging  
Na<sup>+</sup> – Sodium ions  
NCA – Nurse controlled analgesia  
NCAS – National Clinical Assessment Service  
NCEPOD – National Confidential Enquiry into Perioperative Deaths  
NCSA – National Care Standards Authority  
NHS – National Health Service  
NICE – National Institute for Health and Clinical Excellence  
NPSA – National Patient Safety Agency  
NSAIDs – Non-steroidal anti-inflammatory drugs  
NTN – National Training Number  
O<sub>2</sub> – Oxygen  
OAA – Obstetric Anaesthetists Association  
OSCE – Objective Structured Clinical Examination  
PAS – Patient administration system  
PCA – Patient controlled analgesia  
pCO<sub>2</sub> – Partial pressure of carbon dioxide  
PD – Programme Director  
pH – acidity measurement  
PICU – Paediatric Intensive Care Unit  
PMETB – Postgraduate Medical Education and Training Board  
pO<sub>2</sub> – Partial pressure of oxygen  
PPH – Post-partum haemorrhage  
RCoA – Royal College of Anaesthetists  
RA – Regional Adviser  
RITA – Record of in-training Assessment  
    RITA A – Core information on the trainee  
    RITA B – Changes to core information  
    RITA C – Record of satisfactory progress  
    RITA D – Recommendation for “targeted training” (stage 1 of “Required Additional Training”)  
    RITA E – Recommendation for intensified supervision/repeated experience (stage 2 of “Required Additional Training”)

RITA F – Record of Out-of Programme Experience  
RITA G – Final record of satisfactory progress  
RSI – Rapid sequence induction  
SASG – Staff and Associate Specialist Grade  
SCATA – Society for Computing and Technology in Anaesthesia  
SI - Système Internationale  
SIGN – Scottish Intercollegiate Guidelines Network  
SpO<sub>2</sub> – Oxygen saturation  
ST – ST segment of the ECG  
TIVA – Total Intravenous Anaesthesia  
Type I training programme – a higher specialist training programme leading to the award of  
a CCT  
Type II training programme – a higher specialist training programme that does not lead to the  
award of a CCT  
VE – Ventricular ectopic  
VF – Ventricular fibrillation  
VT/Tach – Ventricular tachycardia

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**APPENDIX B:**

**The Royal College of Anaesthetists**  
**Application for Recognition of FTSTA/FTTA/LAT Posts towards CCT Training**

***Part 1 to be completed by Trainee***

<b>Personal Details</b>			
Name:			
School of Anaesthesia:			
College Reference No:		NTN/VTN:	
Date of Primary FRCA (or equivalent):			
<b>FTTA / LAT post/s</b>			
Name of Hospital	Dates from/to: (dd/mm/yy)	Training units undertaken	

Please state how much of the above training period you wish to be considered towards your CCT:

.....  
 .....

Signature ..... Date:.....

***Part 2 to be completed by Programme Director/Regional Adviser where the training was taken***

Please state how much of the above training in your opinion should be counted towards the trainee's CCT training, and at what level. Please indicate what supporting documentation is held locally of satisfactory assessments e.g. RITAs, work place assessments etc.

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Name: ..... Signature:..... Date: .....

**Please return to: Training Department, The Royal College of Anaesthetists,  
 35 Red Lion Square, London WC1R 4SG**

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## APPENDIX C:

### THE MANAGEMENT OF SICKNESS, PARENTAL AND MATERNITY LEAVE

1. The effect of any absences or changes to the training programme resulting from *any* type of sickness, parental or maternity leave should be assessed on an individual basis by the Local Specialty Training Committee. The legal requirement is set out in Schedule 5 to the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 which relates to this issue *and is non-negotiable*, stated that:
 

“Training may be interrupted for reasons such as military service, secondment, pregnancy or sickness. The total duration of the training shall not be reduced by reason of any interruption”.
2. **Sickness, parental or maternity leave** In a competency based programme trainees are to be assessed and signed off on the basis of competences achieved not the time taken to obtain them. Thus normally periods of absence due to sickness, parental or maternity leave are irrelevant. In the event of prolonged absence a period of re-orientation may be needed before further competences can be taught and assessed.
3. **Casual sick leave** When casual sick leave starts to affect training, all that is required is a simple statement from the Regional Adviser that the effect of the leave has been discussed, that the programme has been adjusted to take account of the individual trainee and that the forecast CCT date has been revised as necessary.
4. **Long term sick/parental/maternity leave** The College expects Local Specialty Training Committees and Programme Directors to come up with sensible recommendations for individual cases. An example of the way the College expects this to be applied in practice is:
  - A trainee has a car accident or is pregnant which results in her being absent from work for a period of 4 months. Her projected CCT date would *provisionally* be advanced by 4 months. On returning to work, the situation would be discussed with the Programme Director to agree a plan for future training and a revised CCT date.
  - If the trainee had missed a crucial 3-month block of training that could not be obtained within the remaining period of the CCT programme, the CCT date would have to be delayed until that period of training was covered.
  - If on the other hand the missed training objectives were more general e.g. obtaining management or teaching experience, then it is more likely that with extra effort some of the lost time could be made up in the remaining time available. In this instance the CCT date would still be delayed, but by a reduced amount.
5. **Clinical duties of pregnant trainees** - This is a potentially complex area where advice must be sought from the occupational health and personnel departments. With regard to out of hours duties Croner’s information service states that:

“Where a new or expectant mother works at night and a certificate from a registered medical practitioner or a registered midwife shows that it is necessary for her health and safety that she should not be at work for any period, the employer must find suitable alternative work or suspend her from work for so long as is necessary ... the employer is not required to take the above actions until the employee has notified them in writing that she is pregnant, has given birth within the previous six months or is breastfeeding. The

employer may request, in writing, a certificate from a registered medical practitioner or a registered midwife confirming the pregnancy. If within a reasonable period of time, the employee has not produced the certificate, the employer is not required to continue with the requirements detailed above.”

## APPENDIX D

### CRITERIA FOR APPOINTMENT OF TRAINERS IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

This document sets out criteria for the appointment of trainers, including extending recognition as trainers to those who have been appointed *other* than by standard NHS Advisory Appointments Committees (AAC). It also takes into account that some postgraduate training may have to be delivered in hospitals outside the NHS.

#### Training in the NHS

Clinical training is ordinarily delivered in NHS hospitals by consultants, approved staff and associate specialist (SAS) grades,<sup>25, 26</sup> and by senior trainees. They are supported by Regional Advisors (RAs) and College Tutors (CTs) appointed by the Royal College of Anaesthetists (RCoA), or the Intercollegiate Board for Training in Intensive Care Medicine (IBTICM), and by educational supervisors appointed locally.

PMETB is responsible for approving posts and programmes for training, in conjunction with the Postgraduate Deans (advised by the RCoA).

The example of trainers and teachers has a powerful influence upon the standards of conduct and practice of trainees.<sup>27</sup> It follows that all those involved in training and teaching should recognise and meet their responsibilities.<sup>28</sup> In particular:

- Consultant and SASG anaesthetists involved in the training or education of trainees should be aware of the objectives of the training programme and participate in its optimal construction and delivery.
- Consultants, SAS grades and others involved in teaching must fulfil the CPD requirements for the clinical appraisal process.
- Trainers and teachers should take steps to acquire the skills of a competent teacher.<sup>29</sup>
- All should fulfil the essential and fulfil or at least aspire to the desirable criteria (see below)

#### Consultant trainers

- The AAC committee at which the College is represented is a check on the suitability of a consultant as a trainer.
- Consultant-trainers in the NHS must be listed in the Specialist Register and have been appointed to a substantive NHS consultant, University, or Defence Medical Services post by a properly constituted AAC. Subject to the local CT's agreement, expressed by matching trainees to the consultant's training capacity, recognition of such appointees as trainers is automatic.

**SASG trainers** The RCoA encourages CTs to identify SAS doctors with aptitude and to nominate them as teachers to the local School of Anaesthesia, specifying their areas of expertise. Those who undertake teaching must have opportunity to acquire the skills of a competent trainer.

**Trainees as trainers** By the time they complete their CCT programme trainees must have learnt to assume responsibility for the supervision of more junior trainees. As part of their

<sup>25</sup> *Post-graduate examinations and SASG anaesthetists.* [www.rcoa.ac.uk](http://www.rcoa.ac.uk) >Professional Standards>Advisory Appointments Committees.

<sup>26</sup> *Non consultant career grade doctors.* College Bulletin 2001: 9;407

<sup>27</sup> *The doctor as teacher,* GMC 1999, paragraph 1

<sup>28</sup> *Good medical practice,* GMC 1998, paragraph 10

<sup>29</sup> *The doctor as teacher,* GMC 1999, paragraph 5

preparation for becoming a consultant, senior trainees should have the opportunity to contribute to the organisation and delivery of formal training under the supervision of the CT or other designated trainers.

## Trainers in NHS Foundation Hospitals and the Independent Sector

NHS consultants and SASGs who have been recognised as trainers, as described above, carry their personal recognition when working outside their NHS base.

Consultants and SASGs appointed to posts in Foundation Trusts that do not use College representation for AACs, to Independent Sector Treatment Centres or to Independent Hospitals do *not* have automatic recognition as trainers. In such instances the College will offer recognition in a personal capacity:

- **Foundation Trusts** In the case of Foundation Trusts when no College representation has been used during selection, the College delegates its authority to the local CT.
- **ISTCs** In ISTCs, private hospitals or any other institution without a CT, the College delegates this authority to the local RA or Deputy.

In both instances the following criteria<sup>30</sup> should be used as guidance for recognition, which should follow a meeting between the CT or RA and the consultant.

- **Essential criteria**
  - the trainer's employing institution *must* be integrated into the local school of anaesthesia
  - willingness to teach and commitment to deliver 'hands on' teaching and training including preoperative and postoperative care
  - regular clinical commitment (e.g. in operating theatres, clinics, critical care units)
  - listing in the GMC Specialist Register
  - compliance with current GMC revalidation requirements
  - successful completion of annual assessment or appraisal by a consultant anaesthetist
  - robust evidence of recent continued professional development (CPD) normally based on the previous two years
  - being up-to-date and supported in a post with protected time for further CPD
  - familiarity with the assessment procedures and documentation of the knowledge, skills and attitudes components of competency based training
  - willingness to assess continuously the trainee throughout the appointment, and to complete trainees' assessment forms on a regular basis as necessary
  - participation in audit
  - safeguarding trainees' attendance at core curriculum teaching meetings.
  - ability to detect the failing trainee.
- **Desirable criteria**
  - successful completion of a 'Training the Trainers' course or equivalent
  - ability to use educational technology
  - familiarity with teaching evidence-based medicine
  - ability to provide remedial support to the trainee in difficulty
  - willingness to guide and stimulate trainees to carry out audit and if appropriate clinical research.
  - willingness to ensure that the volume and content of training lists and other sessions reflect the additional time required for training.
  - willingness to mentor individual trainees

28 November 2006

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<sup>30</sup> The criteria are common to all trainers; those who have already gained recognition should use them as a guideline for maintaining their skills as trainers.

## **APPENDIX E:**

### **COMMUNICATION SKILLS, ATTITUDES AND BEHAVIOUR**

Professional practice implies the possession of attitudes and behaviour that ensure continued, safe clinical practice together with a respect for the wishes and sensitivities of patients, colleagues and other members of staff. The confirmation that a trainee has such attributes is part of the 'Workplace Assessment' and must be included in the *Professional Portfolios* (Appendix 15).

#### **Communication skills**

A wide range of different communication skills is required, reflecting the varied nature of effective modern anaesthetic practice in the UK. These can be classified into two main areas:

- communication with patients (including guardians and relatives) and
- communication with other members of staff.

Annex 1 contains a tabular version of the qualities identified by the GMC as necessary for professional, safe clinical practice. It first gives an example of an assessment form and then lists desirable and undesirable qualities associated with each area of assessment

#### ***Communication with patients***

As with other acute specialties anaesthetists should attempt to provide conditions which inspire confidence and trust on the part of the patient and so facilitate gathering of information and an explanation of the likely course of events. On some occasions the nature and severity of the patient's underlying condition may require that surgical procedures are postponed or even cancelled. It is especially important that dialogue in such cases is conducted in a clear, objective fashion at a level of comprehension appropriate to the patient and in a way that is sensitive to the patient's concerns.

On other occasions, such as in the intensive therapy unit, communicating with patients is made difficult because of the inability of the patient to speak because of the level of respiratory support being provided. In addition to these challenges maintaining a rapport with relatives, who are often understandably anxious, is a key skill. Such a rapport makes dialogue about issues such as withdrawal of active intervention or describing a worsening prognosis less difficult.

The above can be expressed in terms of the following competences:

- Is able to establish the confidence and trust of the patient
- Is able to elicit the necessary and relevant information from the patient, including areas of specific concern
- Is able to promote meaningful dialogue with the patient
- Is able to discuss a management plan in terms appropriate to the patient's level of understanding and sensitive to the patient's concerns
- Is able to communicate any risks in a way that the patient can understand
- Is able to obtain informed consent for the anaesthetic management plan
- Is able to convey potentially distressing or disappointing information to the patient in a way that is consistent with the principles of breaking bad news (such as cancellation of surgery, poor prognosis or withdrawal of active therapy)

- Is able to help the patient deal with any complications that may have arisen, including preparation for future anaesthetic interventions (for example, difficult intubation, adverse drug reactions)

All the above skills will require the ability to demonstrate empathy, compassion and sensitivity to the patient's current situation and background. The use of the term patient is taken to include guardians and, where relevant, relatives. Management plans apply to all the clinical settings in which anaesthetists encounter patients, including; perioperative care, intensive therapy units, resuscitation in accident and emergency departments, acute clinical areas (acute pain), outpatient clinics (pre-operative assessment and chronic pain), labour ward and the wider obstetric unit.

**Communication with staff** Anaesthetists do not work in isolation but are members of a network of health care professionals involved with the care of any individual patient. A set of skills is required to ensure that important information and instructions are given to the relevant staff. On other occasions when the potential for conflict arises, anaesthetists must be able to exercise appropriate assertiveness in the interest of the patient. Anaesthetists also need to be receptive to information and suggestions from other members of staff and a key skill is the creation of an environment in the workplace, whether theatre, ITU, labour ward or outpatient clinic, where staff are encouraged to feel that they are part of the team and can interact in the way described in the interest of the patient. The above can be expressed in terms of the following competences:

- The anaesthetist should be able to establish an effective working relationship with other health care staff
- The ability to gather relevant information about the patient
- The ability to share relevant information with staff concerning the management of the patient while respecting issues of confidentiality
- The ability to convey the key components of the management plan, including back up contingency plans (Plan B, Plan C etc)
- The ability to be assertive when promoting the patient's interests
- The ability to provide support to the other members of the team, including emotional support following critical incidents or major incidents

## Attitudes and behaviour

Attitudes and behaviour should be continuously assessed and documented at least annually. Where there are problems with a trainee's attitude and behaviour, more frequent feedback is required, with emphasis on the standards required. In the following pages is a tabular version of the qualities identified by the GMC as necessary for professional, safe clinical practice. It first gives an example of an assessment form and then lists desirable and undesirable qualities associated with each area of assessment but these are meant to be neither comprehensive nor exclusive.

It is expected that most trainees will be satisfactory: for those who are not, the enclosed forms allow patterns of persistent or isolated instances of attitudinal or behavioural difficulty to be identified. These forms are not intended to be purely negative. They are also meant positively to help trainees to modify their approach as they themselves develop e.g. increased assertiveness with increasing knowledge. An underlying principle is that whenever the satisfactory box is not ticked and comments are made, these must be discussed with the trainee.

Evidence shows that most trainees in difficulty have problems in the area of poor communication and attitude rather than in clinical skills. Early identification and referral using Deanery agreed processes are essential, usually via the College Tutor to the local Clinical Tutor, with an action plan within an agreed timescale. If the problem cannot be resolved

locally then support by senior Deanery personnel should be requested. The College Tutor should also involve the Regional Advisor if there are major concerns in this area. The Clinical Director will also need to be involved if patients are involved or poor behaviour has impact on other staff members.

### **Assessment tools**

The following assessment tools can review the above competences

1. Mini-CEX (Anaesthesia)
  - Communication with patient
  - Communication with staff
  
2. DOPS (Directly Observed Procedural Skills)
  - Explanation to patient
  - Obtains consent
  
3. The Anaesthetists' Non-Technical Skills (ANTS) System Although communication pervades this system the elements most closely related to communication are:
 

Identifying and utilising resources

  - Co-ordinating activities with team members
  - Exchanging information
  - Using authority and assertiveness
    - Assessing capabilities of others
    - Supporting others
 (These apply on the whole to communication with staff)
  - Gathering information
  - Balancing risks and selecting options

(These apply to communication with patients and also to communication with staff)
  
4. Multi Source Feedback For trainees who do not respond to these forms of assessment it may be necessary to use 360° Multi Source Feedback (opinions of other members of the team(s) in relation to the domains of Good Medical Practice) to make them aware of their weaknesses.

The frequency with which MiniCEX, DOPS, Multi Source Feedback and the ANTS system are used is currently under discussion. Some of these competences will overlap with others e.g. history taking and explanation both feature in the initial tests of competency. Collecting them together in this fashion allows an overview of the area of communication skills.

For trainees with problems a confidential and less formal appraisal might be a useful format for identifying and addressing the underlying issues.

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**ANNEX 1 to Appendix E****ASSESSMENT OF COMMUNICATION SKILLS, ATTITUDES AND BEHAVIOUR**

Please put a tick in the appropriate box. Any 'cause for concern' must be qualified with information.

This form should be completed annually or whenever a trainee rotates between hospitals. If difficulties arise, it can be used more frequently.

<b>Attitude or behavioural pattern</b>	<b>Satisfactory</b>	<b>Cause for concern</b>	<b>Please give examples of cause for concern, noting date. Expand on a separate sheet if necessary</b>	<b>Initials of assessors (with dates)</b>
<b>Communication Skills (I: with patients and relatives)</b>				
<b>Communication Skills (II: with staff)</b>				
<b>Communication Skills (III: sensitivity to another's needs)</b>				
<b>Reliability and time-keeping</b>				
<b>Control of moods and emotions</b>				
<b>Personal presentation</b>				
<b>Social behaviour</b>				
<b>Conscientiousness in checking</b>				
<b>Initiative</b>				

<b>Over or under assertiveness</b>				
<b>Over-confidence</b>				
<b>Under-confidence</b>				
<b>Departmental involvement</b>				
<b>Team working</b>				
<b>Personal organisation</b>				
<b>Honesty and trustworthiness</b>				
<b>Enthusiasm</b>				
<b>Record keeping (log book and anaesthetic records)</b>				

I confirm that any 'causes for concern' have been discussed with the trainee. The outcome of these discussions was as follows:

.....  
 .....

Signed..... Name (print).....Date.....

### Examples of communication skills, attitudes & workplace behaviour that might cause concern

The table below gives examples of the types of behaviour pattern, which may cause concern. The descriptions in the boxes are intended only to be vignettes of possible adverse occurrences: they are not intended to be either prescriptive or exclusive.

Attitude or behavioural pattern	Example of minor problem	Example of serious problem
<b>Communication Skills (I: with patients and relatives)</b>	Occasional communication difficulties with patients or relatives have been noticed	Repeated communication difficulties with patients and relatives have been noticed. Others have commented on them.
<b>Communication Skills (II: with staff)</b>	Occasional communication difficulties with staff have been noticed e.g. handover, ward round	Repeated communication difficulties with staff have been noticed. Others have commented on them. Fails to pass on important clinical information.
<b>Communication Skills (III: sensitivity to another's needs)</b>	On occasions fails to listen to patients or relatives or to respect their wishes. Occasionally lacks sensitivity in handling patients.	Appears oblivious of what patients and relatives say. Seems to press on within his/her own cultural and ethical reference frame despite the wishes of patients and relatives
<b>Reliability and time-keeping</b>	Isolated episodes of lateness, sometimes fails to warn of problems, tends to need reminding to get things done.	Repeated episodes of lateness, often fails to warn of problems, usually needs reminding to get things done
<b>Control of moods and emotions</b>	Occasionally shows irritability or bad temper with no apparent cause. Although other staff are aware of it, work continues normally.	Is well known for being moody, irritable and bad-tempered. Other staff modify their behaviour to accommodate them. The pattern of work is adversely affected
<b>Personal presentation</b>	When seeing patients, occasionally dresses in an unprofessional way. Occasionally wears inappropriate accessories.	Frequently dresses in an unprofessional way when seeing patients. Wears accessories which patients may find distasteful. Other aspects of personal hygiene sometimes cause offence
<b>Social behaviour</b>	Social life occasionally impinges on professional life causing lateness, tiredness at work, and difficulty with studies.	Social life repeatedly affects professional performance, is likely to be causing problems with self-directed learning and affects patient care.
<b>Conscientiousness in safe practice</b>	Usually satisfactory but has occasional lapses (e.g. doesn't sign controlled drugs book, forgets to switch alarms on). If running late may omit routine checks.	Frequently observed not to carry out routine checks of equipment. Has too many 'near misses' for comfort. Theatre staff comment on 'slap dash' approach. Doesn't record critical incidents
<b>Initiative</b>	Rather passive. Tends to need pushing when things have to be done. Slower than he/she should be to take responsibility.	Actively avoids taking up challenges and very slow in adopting responsibility as and when problems arise
<b>Over or under assertiveness</b>	(I) On occasions undertakes inappropriate procedures because of pressure from others. Known to be someone who usually 'won't argue'. (II) On occasions insists on a course of action in the face of reasonable advice to the detriment of patients and/or colleagues	(I) Rarely presses their argument, even when they know they are right. Fails to be assertive when necessary even to the patient's detriment. Unable to control any situation. (II) Frequently causes problems and offends patients and/or colleagues by insisting on a course of action in the face of reasoned argument.

<b>Over-confidence</b>	Occasionally takes on cases which are beyond level of competence. Occasional clinical crises occur because of lack of proper planning and assessment.	Frequently exhibits lack of care in planning and execution of tasks. Works without concern beyond his/her level of training, knowledge or experience.
<b>Under-confidence</b>	Reluctant to extend clinical experience. Anxious when working alone on clinical cases that should be within his/her competence.	Frequently demonstrates and transmits anxiety to the theatre environment. Is sufficiently stressed by work that symptoms of stress become an issue and affect performance.
<b>Departmental involvement</b>	Participation below the usual expected. Tends not to attend meetings unless he/she has to. Reluctant to take part in social activities related to the department.	Rarely participates in any departmental activity. Rather isolated socially from other members of the department.
<b>Team working</b>	Doesn't always consider the needs of others. Tends to press ahead with his/her own plan and expects others to adapt around it.	Careless of the needs of others. Often arrogant and thoughtless. Sufficient lack of insight that his/her behaviour frequently causes problems.
<b>Personal organisation</b>	Can be unprepared for the task in hand: sometimes forgets to bring essential items to meetings etc. Can be slow to implement agreed policy changes.	Frequently poorly prepared and disorganised. Unreliable to the extent that other staff are affected. Appears unaware of the impact their behaviour has on the working environment.
<b>Honesty and trustworthiness</b>	Has been found to tell manipulate the truth to prevent criticism; e.g. says a premed was not given when it was never actually written up; blames others for his/her own shortcomings	Deliberately misleads staff, patients or trainers by mis-information e.g. fills in logbook with non-existent cases; does not report serious adverse event; alters records after a problem has occurred. Fails to answer patients queries honestly (e.g. risks of a procedure)
<b>Enthusiasm</b>	Usual response to new opportunities is rather flat. Gives the appearance that work is an onerous duty rather than something to give satisfaction	Negative response to new opportunities. Every silver lining is surrounded by a black cloud. Never volunteers and is unco-operative in solving departmental problems
<b>Record keeping</b>	Occasionally fails to keep a good record or is rather economical with basic information. Always has to be asked to sign the controlled drugs' book.	Case notes review demonstrates frequent poor record keeping; key items of information missing or incorrectly documented. Training record poorly maintained, possibility of false entries.

## **APPENDIX F:**

### **THE RESPONSIBILITIES OF PROFESSIONAL LIFE**

#### ***What is Professionalism?***

- The nature of professionalism is controversial, and two contrasting views of professionalism have arisen.<sup>31</sup>
  - The *technical / rational* view is a mechanistic one, where professionals deliver a service through a predetermined set of clear-cut routines and behaviours. This rule-based approach is widely held by politicians, the press and the public.
  - In contrast, the *professional artistry* view holds that far from being simple and predictable, professional practice in the real world involves making complex decisions relying on a mixture of professional judgement, intuition, and common sense.
- An important component of professionalism is the need for *reflective behaviour*. Because practice changes rapidly, doctors need continuously to refine and update their expertise. By questioning their own practice and challenging theory with ideas from other perspectives, doctors will not only improve their own practice, but will allow both the art and science of anaesthesia to flourish.

***Characteristics of professions*** Professions share a number of common characteristics, including:<sup>32</sup>

- a discrete body of knowledge and skills;
- control and organisation by associations which are independent of government;
- professional authorities have ultimate authority on affairs relating to their domains;
- admission requires long education / training / qualifications – controlled by the profession
- responsibility for ethical and technical criteria;
- right and duty to discipline unprofessional conduct;
- autonomy of individual members within limits laid down by their associations, and legal limits;
- provision of a service to the public; and
- an expectation that members will value service above reward, and are held to higher standards of behaviour than non-professionals.

#### ***Origins - the healer and the professional***

- Our traditions originated from Hippocrates, and the Hippocratic oath has served as the foundation of morality in medicine. Being a healer is not enough. As professionals doctors are obliged to undertake other duties too.
- The relationship between professionals and the public is based upon an understanding. The public confers professional status upon us in the understanding that it will receive its part of the bargain; properly organised and safe healthcare. Thus professional status is a privilege rather than a right and so can be modified or withdrawn if society is not satisfied with our performance as professionals.

***Professionalism and self regulation*** Independence (autonomy) rests on the three pillars of *expertise, ethics, and service*<sup>33</sup>.

- *Expertise* - from knowledge and skills, informed by audit and research;
- *Ethics* - from values and standards. Commitment, caring, competence, and integrity; and
- *Service* - from a vocational commitment to put patients first.

<sup>31</sup> Developing Professional Judgement. Fish D, Coles C. Butterworth Heinmann 1998.

<sup>32</sup> Professionalism must be taught. Cruess SR, Cruess RL. BMJ 1997;315:1674-7

<sup>33</sup> The performance of doctors: I: professionalism and self-regulation in a changing world. Irvine D. BMJ 1997;314:1540

### **Maintaining trust**

- Patients ultimately must be able to trust doctors. Unfortunately, there appears to be a crisis of trust that has led to a drive towards accountability.<sup>34 35</sup> These pressures have affected all professions and are driving changes in both training and practice.<sup>36</sup>
- The understandable attempts of successive governments to improve safety, have resulted in a huge increase in the complexity of the system in which doctors work. A large number of organisations are now involved, often with functions that overlap. Some of these are listed below:
  - the *government* has produced a number of papers<sup>37 38 39 40</sup> introducing the concept of Clinical Governance, resulting in the formation of a number of new organisations including:
    - the National Institute for Health and Clinical Excellence (NICE) to advise on best practice;
    - the Healthcare Commission (HC) to ensure that all hospitals comply with best practice;
    - the National Clinical Assessment Service (NCAS) to advise Hospital Trusts and other authorities on the management of failing doctors; and
    - the National Patient Safety Agency (NPSA) to promote patient safety
    - the Postgraduate Medical Education and Training Board (PMETB) assumed responsibility for standards of postgraduate education for all doctors in 2005, a role traditionally held by the Royal Colleges.

The Chief Medical Officer published a consultation document in 2006 (*Good doctors, safer patients*) suggesting new mechanisms for the revalidation of doctors and arguing for substantial reform of the General Medical Council.

- The *General Medical Council (GMC)* was established by the Medical Act of 1858, in order to maintain a register of doctors, and has the legal responsibility to discipline doctors. It has published a number of guides relevant to professional practice<sup>41 42</sup>. It introduced the concept of revalidation for UK doctors<sup>43</sup>, involving the use of personal portfolios, annual appraisal, and 5-yearly external review by a 'revalidation group' of medical and lay people;
- *Hospital Trusts* are required to implement Clinical Governance. In addition, the Clinical Negligence Scheme for Trusts (CNST), the Scottish Clinical Risk and other Risk Indemnity Scheme (CNORIS) and the Welsh Risk Pool, are insurance schemes which provide Trusts with indemnity provided that certain practices are followed. This limits the professional freedom of doctors, albeit with the laudable aim of increased patient safety<sup>44</sup>;
- The *British Medical Association (BMA)* justifiably claims to be more than a trade union for doctors. Although initially hostile to appraisal, the BMA altered course, and the

<sup>34</sup> Myerson KR. Editorial: Appraisal and revalidation need sensitive handling. *Anaesthesia* 2001; **56**: 199-201.

<sup>35</sup> Charlton BG. The ideology of 'accountability'. *Journal of the Royal College of Physicians of London* 1999; **33**: 33-35.

<sup>36</sup> Myerson KR. Editorial: Can we assess Professional Behaviour in Anaesthetists? *Anaesthesia* 1998; **53**: 1039-1040

<sup>37</sup> Department of Health, 1998. *A First Class Service: Quality in the New NHS*. The Stationery Office, London.

<sup>38</sup> Department of Health, 1999. *Supporting Doctors, Protecting Patients*. The Stationery Office, London.

<sup>39</sup> Department of Health, 2000. *The National Plan for the NHS in England*. The Stationery Office, London.

<sup>40</sup> Department of Health, 2000. *An Organisation with a memory*. The Stationery Office, London.

<sup>41</sup> Good Medical Practice. The General Medical Council 2006, London

<sup>42</sup> Maintaining Good Medical Practice. The General Medical Council 1998, London

<sup>43</sup> General Medical Council, 2000. *Consultation Document on Revalidation*. GMC, London

<sup>44</sup> In Northern Ireland each Trust has its own risk assessment and negligence scheme.

Central Consultants and Specialists Committee (CCSC) negotiated and agreed a consultant appraisal scheme with the DOH;

- *The Royal College of Anaesthetists* (RCoA) has responsibility for setting the professional standards for anaesthetic practice. In 1997, the RCoA and the *Association of Anaesthetists of Great Britain and Ireland* (AAGBI) formed the Joint Committee on Good Practice (JCGP). This committee has published a guide, 'Good Practice',<sup>45</sup> and has produced guidance to assist with appraisal and re-validation;<sup>46</sup>
- the *public* increasingly demonstrates a consumerist approach to the provision of professional medical services;
- the *media* often encourage the persistence of an adverse 'blame' culture by focussing on disaster and seeking to apportion blame;

*Our obligations* As can be implied from the number of organisations involved, our professional obligations extend widely, and far beyond contractual obligations to an employer. The joint RCoA / AAGBI 'Good Practice' guide gives excellent practical advice on our obligations as anaesthetists, whilst the various GMC publications best sum up the wider professional obligations as doctors towards good practice.

### **Training for professionalism**

Professional behaviour underlies all aspects of medical training and is learnt as a continuum from medical school onwards throughout professional life. Because of its nature, much is learned implicitly in an apprenticeship style of training, so called *tacit* or hidden, learning. By mapping with the requirements of 'Good Medical Practice' (GMP), the RCoA curriculum ensures that trainees develop attitudes and behaviour that are appropriate for professional life.

### **Acquisition of competences**

- During years ST 1 and 2 emphasis is placed on the acquisition of skills in communication and the assessment and treatment of patients.
- In years ST 3 and 4 professional obligations are widened to include more complex aspects of behaviour associated with the care of patients
- Years ST 5 and 7 should include teaching, training and management skills.

**Assessment of competences** At all stages, of training, professional behaviour is assessed using a combination of assessment methods. These include assessment instruments such as Multisource Feedback (MSF). Other assessment instruments include a component of professionalism, including the Mini-Clinical Evaluation Exercise (Mini-CEX), Cased Based Discussion (CBD) and Direct Observation of Procedural Skills (DOPS). Information from assessments is used in appraisal to inform, help and encourage trainees to develop professional behaviour. Assessment results may also be used at Annual Review to inform the progress of trainees towards their achievement of a CST.

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<sup>45</sup> The Royal College of Anaesthetists and The Association of Anaesthetists of Great Britain and Ireland: *Good Practice: A Guide for Departments of Anaesthesia: 2<sup>nd</sup> edition 2002.*

<sup>46</sup> The Royal College of Anaesthetists and The Association of Anaesthetists of Great Britain and Ireland: *Draft Guidance on Appraisal for Anaesthetists: March 2000 and Personal Folder: April 2002.*

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## **APPENDIX G:**

### **TEACHING AND MEDICAL EDUCATION**

The GMC document '*The Doctor as Teacher*' (1999) contains the following statements about the educational obligations of all doctors:

- All doctors have a professional obligation to contribute to the education and training of other doctors, medical students and non-medical healthcare professionals on the team.
- Every doctor should be prepared to oversee the work of less experienced colleagues and must make sure that students and junior doctors are properly supervised.
- Teaching skills are not necessarily innate, but can be learned. Those who accept special responsibilities for teaching should take steps to ensure that they develop and maintain the skills of a competent teacher.

The third requirement above is expanded by the GMC in '*Good Medical Practice*' (2001):

'If you have responsibilities for teaching you must develop the skills, attitudes and practices of a competent teacher. You must also make sure that students and junior colleagues are properly supervised.'

Assessment and appraisal are important skills for any doctor with responsibility for education and the GMC places strong emphasis on this:

'You must be honest and objective when appraising or assessing the performance of any doctor, including those you have supervised or trained. Patients may be put at risk if you describe as competent someone who has not reached or maintained a satisfactory standard of practice.'

This need for honesty applies equally to the content of references for job applications.

The personal attributes of a doctor with responsibilities for clinical training / educational supervision will include:<sup>47</sup>

- an enthusiasm for his/her specialty;
- a personal commitment to teaching and learning;
- sensitivity and responsiveness to the educational needs of students and junior doctors;
- the capacity to promote development of the required professional attitudes and values;
- an understanding of the principles of education as applied to medicine;
- an understanding of research method;
- practical teaching skills;
- a willingness to develop both as a doctor and as a teacher;
- a commitment to audit and peer review of his/her teaching;
- the ability to use formative assessment for the benefit of the student / trainee; and
- the ability to carry out formal appraisal of medical student progress / the performance of the trainee as a practising doctor.

An anaesthetic trainee should become competent in the teaching and training of healthcare professionals such as junior doctors, medical students and nurses. Specialist Registrars in Years 3, 4 & 5 must learn to assume responsibility for the supervision of more junior trainees, particularly when they are working as a team, for instance out of hours. The more senior

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<sup>47</sup> General Medical Council. *The doctor as teacher*. London: GMC, 1999

trainee will act as an important role model for the junior trainee as well as a source of practical training advice. The example of the teacher is a powerful influence upon the standards of conduct and practice of every trainee, whether medical student or junior doctor. As a part of their preparation for becoming a consultant, senior SpRs should have an opportunity to contribute to the organisation and delivery of formal teaching in the department under the supervision of the College Tutor or other designated trainer.

**Competences** Competency in teaching and medical education for anaesthetists should encompass the following elements:

- *Knowledge*
  - Principles of adult education.
  - Principles of effective communication and teaching.
  - Principles of appraisal, assessment and evaluation.
  - Components of an effective learning environment.
  - Principles of supervision and mentoring.
  - Practicalities of educational supervision in anaesthesia: the roles and responsibilities of the Royal College of Anaesthetists, Regional Advisors, College Tutors, Programme Directors, Postgraduate Deans and individual teachers and trainers.
  - Requirements for life-long learning: continuing education and professional development; developing an appreciation of its importance, its availability and funding.
  - Role of simulators in anaesthetic education.
- *Skills*
  - Planning teaching and learning.
  - Supervision of junior trainees and other learners.
  - Small group teaching.
  - Teaching in the operating theatre.
  - Clinical teaching: ward rounds or outpatient clinic.
  - Teaching practical skills.
  - Preparing and delivering a lecture or presentation.
  - Effective use of appropriate teaching aids.
  - Preparing candidates for examination.
  - Assessment and appraisal.
  - Giving feedback effectively.
  - Evaluation of teaching and courses.
- *Attitudes*
  - Display personal commitment to teaching and learning.
  - Display sensitivity and responsiveness to the educational needs of students and junior doctors.
  - Display required professional attitudes and values.

### **Objectives**

- To become an effective supervisor and teacher of students and junior colleagues.
- To be capable of performing objective and reliable appraisal and assessment.
- Able to contribute to the department's formal teaching programme by presenting reviews, case reports and research projects at conferences and tutorials.
- To be able to make the best use of audio-visual aids.

**References and reading list**

Bayley T, Drury M (eds) *Teaching and Training Techniques for Hospital Doctors*. Radcliffe, Abingdon 1998

General Medical Council. *The doctor as teacher*. London: GMC, 1999

General Medical Council. *Good Medical Practice*. London: GMC, 2001

Jolly B Grant J (eds) *The Good Assessment Guide*. Joint Centre for Education in Medicine. London 1997.

Newble D, Cannon R. *A Handbook for Medical Teachers*. Third Edition. Kluwer, Dordrecht 1994

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## **APPENDIX H:**

### **HEALTH CARE MANAGEMENT**

Trainees need to develop, at a level appropriate to their stage of training, an understanding of the principles of management within the speciality and the National Health Service as a whole. It is recognised that the knowledge and skills will be acquired over the totality of training and will need to be constantly updated due to the changing organisational environment of the NHS. Advanced trainees who anticipate undertaking a leadership role in a clinical service after obtaining CCT will need to further develop the skills of self awareness / understanding and more in depth knowledge of management roles and functions.

#### **Knowledge**

- the structure and running of a department of anaesthesia and intensive care medicine, including the different roles of Departmental Chairman and Clinical Director;
- Develop an understanding of efficient operating theatre and day surgery unit utilisation and Critical Care bed occupancy.
- The responsibility of all doctors as managers as outlined in GMC guidance, Management for Doctors.
- Develop an understanding of the process of committees, how they function and the various roles of committee members, including the chair.
- understand the committee and management structure at local level
- develop an understanding of funding and contracting arrangements in secondary care
- awareness of the responsibilities of the Trust Chief Executive, Medical Director, Nursing Director, Personnel Director, Finance Director, Non-Executive Directors and those of specific Clinical Directors;
- knowledge of risk management and relevant legislation such as equal opportunities and Health and Safety;
- understand the organisational structure of the NHS, at local and national level
- the process of drafting of local clinical guidelines and protocols
- understand the morbidity and mortality reporting systems within the Trust and how these relate to national organisations, e.g. NCEPOD and the Confidential Enquiry into Maternal and Child Health (CEMACH)
- Understanding of complaints – how they arise and how they are managed
- Understand how to access the relevant documents issued by the Departments of Health (including those of the devolved administrations in Scotland, Wales and Northern Ireland), regional health offices, the Royal College of Anaesthetists, and the Association of Anaesthetists.
- the terms and conditions of employment of medical staff, including Trust disciplinary procedures;
- understanding of relevance Trust policies, including Dignity and Respect, in the workplace
- the role and responsibilities of the occupational health department
- understand the responsibilities of a doctor towards his/her patients and colleagues, in particular in the area of fitness to practice;
- the mechanisms purpose and differences between appraisal, performance assessment and revalidation;
- the structure, function and responsibilities of:
  - National bodies such as the Departments of Health, the Healthcare Commission (HC), the National Institute for Clinical Excellence (NICE), the National Patient Safety Agency (NPSA); National Clinical Assessment Service (NCAS); and the NHS Institute for Innovation and Improvement.
  - Specialty specific bodies such as the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland;

- Representative bodies such as the British Medical Association (BMA), the Medical Protection Society (MPS) and the Medical Defence Union (MDU)
- The role, responsibilities and sanctions of the General Medical Council;
- The role of the Postgraduate Deanery in training and the responsibilities of Clinical Tutors within the postgraduate education organisation ;
- The role and responsibilities of the Postgraduate Medical Education and Training Board and the criteria for the awarding of a CCT in anaesthesia;
- The roles and responsibilities of Consultant staff involved in training, Regional Advisors, Programme Directors and College Tutors.

### **Skills**

- Participate in the preparation of day time and/or out of hours rotas for elective and emergency cover of the anaesthetic department, including allocations to educational opportunities.
- attend business meetings of the relevant clinical directorate, including medical equipment purchasing meetings;
- observe appointment interviews for trainee anaesthetists, and other junior non-medical members of the anaesthesia health care team;
- “shadow” a senior member of medical management, e.g. clinical or medical director
- attending the open meeting of the Trust Board
- observing other Trust committees particularly those relating to clinical governance, audit, risk management and critical incident reporting
- basic understanding of how to produce a business plan
- Preparation for committee membership – reading agenda, understanding minutes and action points, background research on agenda items.

### **Attitudes and behaviour**

- Recognition of a team approach, including clinicians, to the management of the service
- Understanding the needs and behaviour of department managers and administrative staff
- A commitment to good communication
- Willingness to discuss budgetary responsibility and implications of clinical decisions on NHS budgets

### **Workplace Training objectives**

- To discuss the management challenges faced by the clinical director / clinical leads
- To discuss financial pressures experienced by the anaesthetic / ICM department and the Trust
- To discuss the role of the College Tutor
- To report critical incidents
- To attend a formal NHS management course
- To attend equality and diversity training, with update every 3 years

### **Recommended Local requirements to support training**

- Willingness of local managers, clinical and non-clinical, to discuss management topics with trainees.
- Inclusion of trainees in committees, where appropriate, as observers or participants

## Relevant Documents

### Royal College of Anaesthetists:

- *Raising the Standard* (“Audit Recipe Book”)
- *Guidelines for the Provision of Anaesthetic Services*
- *Anaesthesia Explained* and *You and your Anaesthetic* (“Patient Information”)
- *Good Practice: a guide for Departments of Anaesthesia, Critical care and Pain Management*
- *Personal Portfolio*
- *Departmental Portfolio*
- *Guidance on Appraisal for Anaesthetists*
- *Role of non-medical staff in the delivery of anaesthesia, 2002*

### The Association of Anaesthetists of Great Britain and Ireland:

- *The Anaesthesia Team, 2005*
- *Guidance on the (new) 2003 Contract and Job Planning for Consultant Anaesthetists, 2005*
- *Consent for anaesthesia, 2006*
- *Anaesthesia in Great Britain and Ireland: a Physician only service, 1996*
- *Consultant – trainee relationships: a guide for Consultants, 2001*
- *Drug and alcohol abuse amongst anaesthetists – guidance on identification and management*
- *Department of Anaesthesia – Secretariat and Administration*
- *Guidance on contracts and workload for Consultant Anaesthetists, 1997*
- *Information and consent for anaesthesia, 1999*
- *Non-consultant career grade anaesthetists, 1998*
- *Fatigue and Anaesthetists, 2004*
- *Risk management, 1998*
- *Stress in anaesthetists, 1997*
- *The anaesthesia team, 1998*
- *Surgery and anaesthesia in general practice premises, 1995*
- *Catastrophes in Anaesthetic Practice, 2005*
- *Theatre efficiency, 2003*

### General Medical Council

- *Management for Doctors, 2006*

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## **APPENDIX I:**

### **INFORMATION TECHNOLOGY**

**Introduction** Advances in Information Management and Technology (IM&T) have made, and will continue to make, radical changes to the way education, training and health care is delivered. To work effectively as a doctor in the NHS a trainee must have an appropriate level of knowledge and understanding of this technology. Trainees need to develop the skills to use the technology effectively in their clinical practice and understand its role in the organisation and planning of services within the NHS. <sup>48</sup>

**General Computing Skills** Trainees should have acquired basic computing skills at an equivalent level to the European Computer Driving Licence and have an understanding of how more advanced skills might be employed in their practice and within the workplace.

- Basic skills that should be acquired by trainees include:
  - General concepts of information technology
  - Managing files/folders, using the computer and storage media
  - Word processing -preparing their curriculum vitae, case reports or scientific papers
  - Spreadsheets –entering data and making simple analyses
  - Presentations – using Powerpoint to deliver a presentation or lecture
  - Databases-understanding how data is stored and retrieved
  - Information and communication – accessing the Internet to search for and retrieve information. Basic communication skills using email
- Advanced skills that trainees might acquire include:
  - setting up and using database programs for audit and research
  - using reference manager software in the production of manuscripts
  - analysing research data with advanced statistical packages (ie SPSS)
  - designing websites
  - setting up intranet networks and servers

**Healthcare Computer Systems** Trainees should have a basic understanding of clinical and non-clinical computer systems used in healthcare delivery on a local and national level. They should be familiar with:

- patient administration systems (PAS)
- electronic patient records (EPR) including anaesthetic record systems and the importance of data quality
- theatre management systems
- integrated care pathways

**Security and Confidentiality** Trainees should understand the importance of security and confidentiality with information systems including:

- local and national NHS protocols for confidentiality and data protection
- GMC guidance
- Personal and professional responsibilities in keeping a logbook
- the role of the Caldicott Guardian
- legislation underpinning this area such as the Freedom of Information Act 2000, Data Protection Act 1998, Computer Misuse Act 1992 and European Directive on Data Protection.

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<sup>48</sup> These competences can be found in *The CCT in Anaesthesia IV: SpR Years 3, 4 & 5* Section 18.

**Data Quality** Effective information systems rely on the accuracy and quality of the data they contain. Trainees should be aware of the issues surrounding data collection and analysis. These include the following areas:

- data entry, validation and error checking
- classification and coding of data (e.g. Read codes);
- basic statistical methodology for research
- quality assurance and audit

**Information / Knowledge Management** Trainees should understand the ways in which information, data and knowledge come together in the development of guidelines and protocols. An understanding of integrated care pathways would be useful to illustrate the place of IM&T in NHS policy and planning.

**Medical Informatics** Medical informatics is the name given to the study of clinical information and communication processes. To be skilled in this area clinicians should be able to:

- understand the dynamic and uncertain nature of medical knowledge and know how to keep up-to-date
- search for and assess knowledge according to the statistical basis of scientific evidence
- interpret clinical data and deal with artefact and error
- analyse and structure clinical decisions in terms of risks and benefits
- adapt and apply clinical knowledge to the individual circumstances of patients
- access, assess, select and apply treatment guidelines, including local adaptation
- structure and record clinical data in a form appropriate for the immediate clinical task, for communication with colleagues, or for epidemiological purposes
- understand the implications of using different media to communicate

### **Further Reading**

Severs M, Pearson C. *Learning to Manage Health Information*. NHS Executive 1999

Greenes RA, Shortliffe EH. *Medical informatics -- an emerging academic discipline and institutional priority*. JAMA 1990; 263(8): 1114-20

Jeremy C Wyatt. *Clinical Knowledge & Practice in the Information Age*. The Royal Society of Medicine Press, 2001

## **APPENDIX J:**

### **MEDICAL ETHICS AND LAW**

Trainees should acquire an understanding of basic health care law, including: the *Bolam* principle, consent, end of life decisions and the criminal law, the legal requirements for record keeping, the Coroner's court, and the ethical principles governing research.

#### **Knowledge**

- Basic health care law, including:
  - The *Bolam* principle.
  - Consent:
    - "Informed" consent.
    - Consent and mental competence, and how to proceed in their absence.<sup>49</sup>
    - Consent and withholding consent in children & the *Gillick* principle.
- Legal requirements for record keeping.
- The Coroner's court and when to refer.
- End of life decisions and criminal law:
  - Limits of treatment.
  - Withdrawing and withholding treatment.
  - Sedation/analgesia & "double effect".
- Ethical principles governing research.

#### **Skills**

- **Good communication skills.**
- Assessment of competence.

#### **Attitudes**

- An empathic, non-coercive approach to the patient.
- Good communication and an empathic approach to the patient and relatives. The incapacitated should be treated as a person.

#### **Research**

- Research is a privilege not a right and patient safety is paramount.
- Planned research must be capable of answering the research question.
- All subjects must consent to being recruited.
- All must have ethics approval.
- Open honest approach to patients and recruits.

#### **Reading List:**

Branthwaite MA: *Law for Doctors: Principles & Practicalities*, RSM 2000.

General Medical Council: *Seeking patients' consent: the ethical considerations*, GMC London 1998

Heneghan CPH: *Patient Consent*, In: *Fundamentals of Acute & Emergency Medicine: Preoperative Assessment*, BMJ 2001

*Information & Consent for Anaesthesia*, AAGBI 1999.

Merry A & McCall Smith A: *Errors, Medicine and the Law*, CUP 2001.

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<sup>49</sup> From July 2002 in Scotland, the *Adults with Incapacity (Scotland) Act* allows Welfare Attorneys or Welfare Guardians to act on behalf of an incapacitated adult. If neither exist then the anaesthetist needs to complete a Certificate of Incapacity. (Further details can be found on the Website – [www.scotland.gov.uk/health/cmo/incapacity\\_act\\_toc.asp](http://www.scotland.gov.uk/health/cmo/incapacity_act_toc.asp))

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**APPENDIX K:****DIRECT OBSERVATION OF PROCEDURAL SKILLS (DOPS) – ST Version (Anaesthesia)**

Please complete the questions using a cross: × Please use black ink and CAPITAL LETTERS																													
Doctor's Surname																													
Forename																													
GMC number:																													
<b>GMC NUMBER MUST BE COMPLETED</b>																													
Clinical setting:	Theatre	ICU	A&E	Delivery ward	Pain Clinic	Other																							
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																							
<b>Procedure:</b>																													
Assessor's position:	Consultant	SASG	SpR	Nurse	Other																								
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																								
Number of times previous DOPS observed by assessor with <u>any</u> trainee:			0	1	2-5	5-9	>9																						
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						
Number of times procedure performed by trainee:			0	1-4	5-9	>10																							
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																						

Please grade the following areas using the scale below:	Below expectations		Borderline	Meets expectations	Above expectations		U/C*
	1	2			3	4	
1 Demonstrates understanding of indications, relevant anatomy, technique of procedure							
2 Obtains informed consent							
3 Demonstrates appropriate preparation pre-procedure							
4 Demonstrates situation awareness							
5 Aseptic technique							
6 Technical ability							
7 Seeks help where appropriate							
8 Post procedure management							
9 Communication skills							
10 Consideration of patient							
11 Overall ability to perform procedure							

\*U/C Please mark this if you have not observed the behaviour and therefore feel unable to comment

**Please record over the page areas of strength or any suggestions for development**

Not at all Highly

Trainee satisfaction with DOPS    1  2  3  4  5  6  7  8  9  10

Assessor satisfaction with DOPS    1  2  3  4  5  6  7  8  9  10

What training have you had in the use of this assessment tool?    Face-to-face  Have read guidelines  Web/CDROM





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**APPENDIX N:****MULTI-SOURCE FEEDBACK: 360° Team Assessment of Behaviour (TAB)**

Trainee's Name: \_\_\_\_\_ GMC No: \_\_\_\_\_ Current post: \_\_\_\_\_ Date started present post: \_\_\_\_\_

Please use the comments boxes to commend good behaviour and to describe any behaviour causing you concern. Give specific examples. This form will be sent to the trainee's educational supervisor, who may ask you privately to enlarge on any concern behaviour you report. At least 9 other forms will also be considered. The trainee will receive private feedback, but you will not be identified in person without advance discussion with you.

<b>ATTITUDE AND/OR BEHAVIOUR</b>	<i>No concern</i>	<i>You have some concern</i>	<i>You have a major concern</i>	<b>COMMENTS:</b> <i>Anything especially good?</i> If you cannot give an opinion due to lack of knowledge of the trainee say so here. <b>You must specifically comment on any concern behaviour, and this should reflect the trainee's behaviour over time – not usually just a single incident</b>
<u>Maintaining trust / Professional relationship with patients</u>  Listens. Is polite and caring. Shows respect for patients' opinions, privacy, dignity and confidentiality. Is unprejudiced.				<p>Leave the form blank if you do not know the person well enough</p>
<u>Verbal communication skills</u>  Gives understandable information. Speaks good English, at the appropriate level for the patient.				

<b><u>ATTITUDE AND/OR BEHAVIOUR</u></b>	<i>No concern</i>	<i>You have some concern</i>	<i>You have a major concern</i>	<b>COMMENTS:</b> <i>Anything especially good?</i> If you cannot give an opinion due to lack of knowledge of the trainee say so here. <b>You must specifically comment on any concern behaviour, and this should reflect the trainee's behaviour over time – not usually just a single incident</b>
<u>Team-working / Working with colleagues</u>  Respects others' roles, and works constructively in the team. Hands over effectively, and communicates well. Is unprejudiced, supportive and fair.				
<u>Accessibility</u>  Accessible. Takes proper responsibility. Only delegates appropriately. Does not shirk duty. Responds when called. Arranges cover for absence.				
<b>Name of assessor:</b>	<b>Post/ designation:</b>		<b>Signature:</b>	<b>Date:</b>

Please send the completed form, straight away, in a sealed envelope, to the postgraduate centre manager

**APPENDIX O:****RECORD OF IN-TRAINING ASSESSMENTS (RITA):  
COPMeD policy on implementing RITAs****(This section may be revised when *Modernising Medical Careers: The Gold Guide to Specialty Registrar Training* is published later in 2007.)****Introduction**

The RITA process is the review by a speciality-based panel of consultant trainers of the assessments which have been carried out during a training post, as well as other evidence of achievements. The panel has two objectives:

- to review the adequacy of the documentation provided and (provided adequate documentation has been presented);
- to make a judgement about the trainee's suitability to progress to the next stage of training, or to confirm that training has been satisfactorily completed satisfactorily.

**In-training assessments**

The RITA panel draws on the evidence of in-training assessments, such as directly observed procedures; case note review; log books; multi-source feedback reports; and other documented evidence of progress of the individual against the standards set out in the curriculum for the specialty. Most curricula state the assessment strategy that is to be used, and this should be made clear to the trainee from the start. Where the relevant College or Higher Training Committee has produced assessment instruments and logbooks or other forms, these should be used. The trainee and the educational supervisor should ensure that assessments are carried out in a timely fashion so that all documentation is completed well before the deadline for submission to the RITA panel. The results of all assessments, and the trainer's report, should be discussed with the trainee before they are submitted to the panel. Occasionally supervisors have been reluctant to do this and have submitted a neutral report, accompanied by a more negative phone call or confidential note to the panel. *This is unacceptable.* Trainees are entitled to a transparent process in which they are assessed against agreed standards, told the outcome of the assessment, and given the opportunity to address any shortcomings.

**Appraisal**

Appraisal as defined in the *Guide to Specialist Registrar Training* is a confidential two-way process during which the trainee and immediate supervisor share their views on how things are going, what has gone well, what could go better, and what needs to be done for the trainee to meet their objectives. This is the ideal opportunity for a discussion of reflective learning and the development of the trainee's personal learning plan. The introduction of *revalidation* based on five years of appraisals alters the ethos of appraisal somewhat, because it is no longer confidential. Given the importance of revalidation, it is important that the NHS appraisal is carried out by someone who is in a position to know the trainee's performance first hand. All trainees are expected to use the NHS Appraisal documentation in addition to, or integrated with, the assessment documentation relevant to their specialty. The NHS Appraisal documentation is the property of the doctor appraised, and may be included as documentary evidence of progress to be considered by the RITA panel.

**RITA Panels**

The RITA panel has an important role, which its composition should reflect. It will normally be drawn from the specialty training committee and, where appropriate, may include an external trainer. All members of the panel should have undertaken equal opportunities training and attention should be paid to maintaining diversity in the pool of consultants

carrying out this role. Since the panel will be taking a view on the adequacy of the documentation submitted, consultant supervisors should not participate in their own trainees' RITA.

### **Documentary Evidence**

The documentary evidence provided will normally consist of the appropriate college assessment forms fully completed by all the relevant trainers and any additional documentation that the specialty may require e.g. exam results; log books; audits; outcomes of mandatory courses; multi-source feedback (also called 360 degree appraisal); evidence of reflective learning etc. Occasionally, it may be necessary for educational supervisors/consultants to provide an additional report giving more detail than the assessment form allows, for example detailing the events that led to a negative assessment. Any documentation taken into account by the panel must have been shared and discussed with the trainee prior to the review taking place. Provided the documentary evidence submitted is complete, and indicates satisfactory progress the trainee may not need to be interviewed in person by the RITA panel (this will be a matter for local agreement) in order for a Form C or G to be issued.

Where the documentary evidence submitted is incomplete, or otherwise inadequate to support a judgement, then no decision should be taken about the adequacy of the trainee until the deficiencies in the documentation have been addressed. It is not acceptable for an interview with the trainee to be used as an alternative to documented in-training assessments. Where there are concerns about the progress of the trainee, and a Form D or E is likely to be issued, it is appropriate to invite the trainee to attend in person and discuss with the panel any additional factors or documentary evidence he or she would like them to take into consideration. *This should not come as a surprise to the trainee, whose trainers should have discussed their concerns with him or her already.*

### **Questions of conduct**

On occasion, trainees have brought allegations of bullying, harassment or other inappropriate conduct on the part of their trainer to the attention of the RITA panel. Such allegations must be taken very seriously, but RITA Panels are not set up to investigate handle allegations of this nature, and are not in a position to deal with them. Allegations about misconduct of either trainers or trainees brought to a RITA Panel should result in a termination of the Panel proceedings in order to allow an investigation by the Deanery, or the relevant employer, as appropriate.

### **Appeals**

The right of appeal, and how to lodge one, should be made clear to every trainee going through the process. It is possible for a trainee to wish to appeal against Form C or G, on the grounds of needing further training time. The details of the appeals process are set out in the *Guide to Specialist Registrar Training*.

### **Career counselling/rotation planning/evaluation of posts**

All of these are important activities, but they are separate tasks from ensuring that in-training assessments are properly documented and reviewed, and used to determine the suitability of the trainee to progress in the programme. In small programmes it may be convenient to carry out several of these tasks on the same occasion, but in larger programmes it will often be more satisfactory for career counselling and rotation planning to be carried out by the programme director or educational supervisor on another occasion. Hearing the trainee's opinion of the post is also important, but it should not be sought at the same time as a judgement is being taken on the trainee's performance.

COPMeD June 2004.

## **APPENDIX P:**

### **RCoA RECOMMENDATIONS FOR PROFESSIONAL PORTFOLIOS AND LOGBOOKS**

#### **Portfolios**

All trainees are required to maintain a Portfolio of training activity. The detail and content will develop and increase as trainees progress from basic, through intermediate, to higher and advanced levels of training. By the end of their training trainees' Portfolios should meet the requirements for NHS appraisal and GMC revalidation of consultants.

The Professional Portfolio is a means of recording the information and collecting the documentation required for regular appraisals and assessments during training. Keeping the Portfolio up to date will conveniently demonstrate the acquisition of the appropriate knowledge, skills, attitudes, and therefore, of competence.

The RCoA is in the process of producing a Professional Portfolio that in due course can be downloaded from the training pages of the College website [www.rcoa.ac.uk](http://www.rcoa.ac.uk).

A Portfolio is best completed on a word processor, a printed copy being presented at Annual Appraisals and Reviews, with the accompanying documentation in a ring binder. The information recorded as a trainee may be easily adapted to complete the Consultant Personal Portfolio in the future. It is suggested that the portfolio is updated continuously and reviewed on a regular basis. This will serve as a stimulus to ensure all training requirements are being fulfilled.

#### **Logbooks, diaries and other records**

Trainees should record, in a suitable paper or electronic logbook, the details of anaesthetics given by them: *this is mandatory*. The only exception being that those in the final two years of training may keep abbreviated details of short, repetitive cases.

The only stipulation that the College makes is that the Logbook Summary section of the personal portfolio must be in the format shown on the following pages or as a report downloaded from the RCoA's electronic logbook.

**ICM** Anaesthetic trainees attached to critical care should maintain a diary of sessions spent in the ICU and a record of procedures learnt and performed. Any trainee with a specific interest in this field should adopt the Intercollegiate Board's record of training at an early stage.

**Pain management** Anaesthetic trainees attached to acute or chronic pain should maintain a diary of sessions spent in these activities and a record of procedures learnt and performed. Any trainee with a specific interest in this field should keep more detailed records from an early stage.

**Obstetrics** A record of obstetric cases and procedures should be kept in a format similar to the Logbook.

#### **Data Protection Act**

If a trainee elects to keep an electronic logbook then they must observe the current requirements of the Data Protection Act.

**LOGBOOK SUMMARY**

(This can be downloaded as a report from the RCoA electronic logbook)

<b>Summary for period:</b>	<b>From:</b>		<b>To:</b>	
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**Specialty & age**

Specialty	Total cases	%	Level of Supervision			Age of patient				
			Direct	Indirect	Teaching others	<1 yr	1-5	6-15	16-80	>80
Cardiac										
Dental										
ENT										
General										
Gynaecology										
Maxillo-facial										
Miscellaneous										
Neonates										
Neuro										
Obstetrics										
Ophthalmics										
Orthopaedics										
Paediatrics										
Plastics										
Radiology										
Resuscitation										
Trauma										
Thoracic										
Urology										
Vascular										
<b>TOTALS</b>										

**Total number of anaesthetics given in this period**

	Total number of cases
<b>Directly supervised</b>	
<b>Indirectly supervised</b>	
<b>Teaching others</b>	

<b>Number of ICU sessions</b>	
<b>Number of acute/chronic pain sessions</b>	

**ASA Grade and level of supervision**

	Direct supervision	Indirect supervision	Teaching others	TOTALS
<b>ASA 1</b>				
<b>ASA 2</b>				
<b>ASA 3</b>				
<b>ASA 4</b>				
<b>ASA 5</b>				

<b>Donor</b>				
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**Age Group and level of supervision**

	Direct supervision	Indirect supervision	Teaching others	TOTALS
<1 year				
1-5 years				
6-15 years				
16-80 years				
>80 years				

**Time of day and level of supervision**

	Direct supervision	Indirect supervision	Teaching others	TOTALS
08.00 - 18.00				
18.00 - 24.00				
00.00 - 08.00				

**Priority and level of supervision**

	Direct supervision	Indirect supervision	Teaching others	TOTALS
Routine				
Day case				
Urgent				
Emergency				

**Teaching experience**

	Non-medical	Medical Student	Junior trainees (ST years 1 & 2)	Senior trainees (ST years 3 to 7)
No of cases				

**Working pattern (based on anaesthetic start time)**

	Weekday			Weekend		
	Day	Evening	Night	Day	Evening	Night
No of cases						

**Modes of anaesthesia**

	Description	Number of cases
<b><i>Primary mode</i></b>		
	GA mask	
	GA LMA	
	GA LMA IPPV	
	GA ETT SV	
	GA ETT IPPV	
	LA	
	Sedation	
	Monitoring only	
	Other	

**Modes of anaesthesia (continued)**

<b><i>Secondary/Regional techniques</i></b>	
Spinal	
Epidural (including CSE)	
Brachial plexus	
Sciatic	
Femoral	
IVRA	
Minor nerve blocks	
Cervical plexus	
Peripheral	
<b>Additional procedures</b>	
RSI	
TIVA	
PA catheter	
CVP line	
Arterial line	
Fibreoptic intubation	
Percutaneous tracheostomy	
Double lumen tube	
Chest drain	
Other (specify):	

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### Useful websites

- Association of Anaesthetists of Great Britain and Ireland – [www.aagbi.org.uk](http://www.aagbi.org.uk)
- British Medical Association – [www.bma.org.uk](http://www.bma.org.uk)
- General Medical Council – [www.gmc-uk.org](http://www.gmc-uk.org)
- International Association for the Study of Pain – [www.iasp-pain.org](http://www.iasp-pain.org)
- Obstetric Anaesthetists' Association – [www.oaa-anaes.ac.uk](http://www.oaa-anaes.ac.uk)
- Pain Society – [www.painsociety.org](http://www.painsociety.org)
- Postgraduate Medical Education and Training Board – [www.pmetb.org.uk](http://www.pmetb.org.uk)
- Royal College of Anaesthetists – [www.rcoa.ac.uk](http://www.rcoa.ac.uk)