



Key Points on the provision of Anaesthesia Services

When considering the provision of anaesthesia, the Royal College of Anaesthetists recommends that the following areas should be addressed. The goal is to ensure a comprehensive, quality service dedicated to the care of patients and to the education and professional development of staff. The provision of adequate funding to provide the services described should be considered.

Summary

- Up-to-date directives, guidance and standards of safe specific anaesthetic practice should be referred to when considering the provision of all anaesthetic services. This includes publications from the General Medical Council (GMC), the Royal College of Anaesthetists (RCoA) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI), government bodies such as the Department of Health (DH) and its Arm's Length Bodies (available on the DH website) and those issued by other recognised learned societies.¹⁻⁵
- An appropriately trained and experienced anaesthetist must be present throughout the conduct of all general and regional anaesthesia for operative procedures, including those procedures requiring intravenous sedation.⁶
- All patients requiring the services of an anaesthetist must undergo appropriate pre-operative assessment and be seen by an anaesthetist before the operation.⁶
- Dedicated skilled assistance for the anaesthetist must be provided in every situation where anaesthesia and sedation are administered.⁷
- Appropriately trained and competent staff must provide care for all patients recovering from anaesthesia or sedation.^{7,8}
- All anaesthetic and monitoring equipment must comply with standards set by the AAGBI.⁶
- All anaesthetic equipment must be fully serviced at the regular intervals designated by the manufacturer and a service record must be maintained. All equipment should be checked by the user before use.⁹
- Departments of anaesthesia must contribute to an acute pain relief service and either have or provide access to a non-acute ('chronic') pain service with nominated lead consultants for each.¹⁰
- Where inter-hospital transfers require an anaesthetist, appropriately trained staff, dedicated equipment and satisfactory safety and personal insurance arrangements must be in place.¹¹
- Departmental guidelines facilitating good anaesthetic practice in accordance with good medical practice and recent national guidance should be in place, observed, regularly reviewed and issued to all members of the anaesthetic department.¹²
- Anaesthetic records should contain the minimum recommended dataset.^{12,13}
- There must be effective mechanisms for the 'hand-over' both of the care of individual patients, and of overall services, providing continuity of care.¹

- Appropriate and sufficient secretarial, administrative and information technology support must be provided for staff working in departments of anaesthesia.^{13,14}
- Appropriate facilities and accommodation must be available for all anaesthetists.¹⁵
- Continuing professional development and revalidation are mandatory requirements for all anaesthetists, including non-consultant and non-training grades.¹ Employers, trusts or otherwise, should ensure that adequate funding is available for this purpose.^{12,16}
- All staff in clinical contact with patients must be appropriately trained in resuscitation skills and maintain their competence in them.¹⁷
- Workload, experience and supervision of trainee staff must satisfy the requirements of the RCoA and AAGBI and training standards must satisfy the PMETB requirements.^{18–21}
- A College Tutor representing the Royal College of Anaesthetists or consultant-in-charge of training must be appointed to organise and co-ordinate anaesthetic training. Dedicated time and administrative support should be provided for this activity, and a second Tutor is recommended for larger departments.²²
- Trainee rotas must be compliant with the 'New Deal' and current Working Time Directive (WTD) regulations without having a deleterious effect on medical training.^{23–25}
- Regular audit and review by departments of anaesthesia to measure activity and to quality assure anaesthetic practice and performance against national standards are essential.¹²
- All anaesthetists should participate in the national anaesthetic audits projects and must contribute to confidential enquiries. Where possible information should be provided for other national and local audits.^{1,26,27}
- Departments of anaesthesia must identify a consultant who is responsible for ensuring that all lists are covered by suitably trained anaesthetists. This consultant should be part of a Theatre Management Group to facilitate optimal theatre efficiency.¹²
- The anaesthetic department must have a clinical director or lead clinician who is an anaesthetist, and appoint lead clinicians who are responsible for essential components of the service. This work must be recognised in the consultants' job plans.¹²
- A critical incident reporting system must be in place and a critical incident co-ordinator appointed. Regular audit, critical incident, morbidity and mortality and managerial meetings should be held and appropriately recorded.¹²
- Adequate arrangements, including time for preparation of documentation, must be made for annual appraisal of all anaesthetists.^{1,12,28–30}
- A system must be in place for dealing effectively with complaints.^{12,31}
- All patients undergoing procedures should be provided with easily understood information materials covering anaesthesia and post-operative pain relief. Preferably they should receive this before they are admitted to hospital, or on admission if this has not been possible.^{12,13}

Introduction

Departments of anaesthesia will be expected to provide adequately staffed, safe and high quality services anywhere that anaesthesia, or sedation requiring the services of an anaesthetist, are provided. The main areas in which they have a responsibility are:

- **Provision of anaesthesia for in-patient surgery, both emergency and elective.** The service encompasses not only care during anaesthesia but pre-operative assessment and preparation of patients, and post-operative care and pain relief.
- **Provision of anaesthesia for out-patient or day surgery.** This will include the selection of suitable patients using medical and social criteria, the choice and planning of suitable facilities and techniques, and the provision of post-operative care and support.
- **Anaesthesia for obstetric services.** This includes antenatal advice and information, analgesia during and following childbirth, the provision of anaesthesia when needed, the provision of resuscitation skills and care for those mothers requiring critical care.
- **Anaesthesia services in critical care.** In all hospitals providing acute medical and surgical services there must be access to appropriate critical care facilities. These should have full-time cover and be sufficiently comprehensive to serve the needs of the patients, so that transfer of patients once treatment has been started is exceptional.
- **Provision of a pain relief service** including services for the relief of acute pain and either provision of or access to a service for the management of non-acute ('chronic') pain.
- **Participation in adult resuscitation services.**
- **Anaesthesia and resuscitation services provided for children.** In some units, provision of anaesthesia for specialist surgery such as cardiothoracic, neurosurgical, and transplant procedures.
- **Provision of anaesthetic services in non-theatre environments.** This includes sites where anaesthesia is administered for electroconvulsive therapy, imaging services, endoscopy, community dentistry and the provision of anaesthesia in the emergency department and for inter-hospital transfers.

Anaesthetists also frequently participate in teaching and training other hospital staff in topics related to their roles, including use of equipment, resuscitation, practical procedures, pain management, and recognition and management of critically ill patients.

Anaesthetists also play a pivotal role in the management of theatre efficiency.

Levels of provision of service

1 Staffing requirements

- 1.1 An appropriately trained and experienced anaesthetist must be present throughout the conduct of all general and regional anaesthesia for operative procedures, including those procedures requiring intravenous sedation.⁶
- 1.2 An anaesthetist must be physically present with the patient whilst administering a general anaesthetic. If in exceptional circumstances the anaesthetist has to leave the patient they must delegate responsibility to another appropriate person in line with GMC guidance on delegation.¹
- 1.3 The level of anaesthetic service for emergency activities, including surgery, must be provided by competent anaesthetists who are either consultants or, if non-consultants, must have unimpeded access to consultants and consultant supervision.
- 1.4 Departments of anaesthesia must ensure that named supervisory consultants are available to all non-consultant anaesthetists and that those they are supervising know their identity, location and how to contact them.^{12,20}
- 1.5 In hospitals receiving patients with major injury and trauma, there must be a sufficient level of appropriately experienced medical and non-medical staff to provide a 24-hour emergency service.
- 1.6 A robust mechanism should be in place to cover for staff absences and local guidance must detail procedures for the appointment of locum anaesthetists if needed.
- 1.7 Consultant work plans should reflect the additional responsibilities of training and direct supervision of trainees while working on full or partial shifts.
- 1.8 All consultants and specialty doctors must have a job plan which is reviewed and agreed annually.

1.9 All staff must have regular annual appraisal.

Pre-operative staffing needs

1.10 All patients undergoing surgery with anaesthesia must be seen by an anaesthetist on the day of operation. This visit should ideally be carried out by the anaesthetist who administers the anaesthetic. Local pre-admission procedures and written information do not replace the final pre-operative meeting between anaesthetist and patient. Further details are available in Chapter 2: Guidance on the provision of anaesthesia services for pre-operative care.

1.11 An anaesthetic pre-assessment service must involve consultant anaesthetists. Adequate medical, nursing and administrative staffing resources are essential for the efficient running of pre-operative anaesthetic assessment clinics for day surgery.

Anaesthetic assistance

1.12 The provision of qualified and competent assistance is essential in every situation where anaesthesia is administered.

1.13 The anaesthetic assistant must be immediately available and provide dedicated assistance to the anaesthetist throughout the entire anaesthetic procedure.

Post-operative staffing

1.14 Until patients can maintain their airway, breathing and circulation they must be cared for on a one-to-one basis by competent and appropriately trained recovery staff.

1.15 Sufficient numbers of recovery staff must be present until a patient is discharged to the ward.

1.16 Adequate provision should be made for a member of the anaesthetic team to visit certain groups of patients within 24 hours following their operation. Specific details can be found Chapter 4: Guidance on the provision of anaesthesia services for post-operative care.

2 Equipment, support services and facilities

Equipment

2.1 All equipment used to provide anaesthesia, including monitoring equipment, should comply with the recommendations of the AAGBI. Health and Safety principles must be observed and compliance with 'Control Of Substances Hazardous to Health' (COSHH) regulations ensured.

2.2 Equipment must be serviced regularly and maintained to a standard of safe working order,

checked by users and records kept of maintenance and checking.

Support services

2.3 Wherever general and regional anaesthesia is administered there must be access to an appropriate range of laboratory and radiological services.

2.4 All hospitals should provide appropriate services for the relief of pain. Acute pain teams, primarily managing pain after surgery, may have wider roles including liaison with outreach and critical care staff. They also need the support of appropriately trained recovery, ward and other support staff to maintain continuity.

2.5 Departments of anaesthesia require an appropriate level of secretarial and administrative assistance to release anaesthetists from clerical tasks, to maintain an organisational base and to contribute effectively to theatre efficiency. The level of support is dependent on the number of consultants and clinical and administrative activity undertaken, but local requirements for such support must be acknowledged and provided for by the employing organisations.

2.6 Departments of anaesthesia must have adequate information technology support to enable immediate access to the electronic patient data, theatre lists and schedules and staffing rotas. In large and complex departments consideration should be given to electronic rota management so that human resources can be released for other important administrative or clinical tasks related to the day-to-day running of the department and patient care.

Guidelines

2.7 Departmental guidelines for all areas of anaesthetic practice, locally determined in accordance with national guidelines, should be established, followed, regularly reviewed and disseminated to the anaesthetic department staff including every new member.

Facilities

2.8 Patients leaving the operating theatre will require specific care in a recovery facility ordinarily located in the theatre complex. Further details are available in Chapter 4: Guidance on the provision of anaesthesia services for post-operative care.

2.9 Specific facilities are required for children.

2.10 Adequate facilities must be available for all staff to take rest breaks, and access refreshments.

- 2.11** Departments of anaesthesia are amongst the largest in the hospital. Staff need accommodation for confidential interviews, teaching and educational activities, provision of books, current medical literature, and information technology including computing and internet access.
- 2.12** When staff are required to be resident or working out-of-hours in the hospital, living and working conditions should meet at least the minimum nationally agreed standards. These include study and rest accommodation, and access to good quality hot and cold food at any time.

3 Areas of special requirement

- 3.1** Specialist services requiring anaesthesia input, for example, provision of anaesthesia for children, critical care, resuscitation, obstetrics and chronic pain, have unique requirements. These are dealt with in later chapters of this document.

4 Training and education

Continuing professional development (CPD) and revalidation

- 4.1** It is a professional obligation of all anaesthetists to take part in and demonstrate evidence of CPD. This underpins the GMC's relicensing and recertification process and the concept of appraisal.^{1,12,16}
- 4.2** A department of anaesthesia cannot be approved for training unless a majority of consultant anaesthetists are up to date with CPD.
- 4.3** CPD activities will include attendance at local, regional and national educational meetings, access to journals and the scientific literature, and use of e-learning programmes. Supporting professional activity time should be protected, and evidence that it has been properly utilised should be available at appraisal. Study leave must be properly funded and educational opportunities provided within the hospital.

Arrangements for trainee anaesthetists

- 4.4** The duties, working hours and supervision of trainees must be consistent with the delivery of high quality safe patient care.¹⁹
- 4.5** Trainee rotas must meet the requirement of the 'New Deal', and European Working Time Directive (EWTD) regulations. It is essential that trainee rotas are designed to maximise training opportunities within the hours constraints of these directives.

- 4.6** Postgraduate training in anaesthesia, intensive care and pain management must be quality managed locally by deaneries, working with the guidance of the Royal College of Anaesthetists, Intercollegiate Board of Intensive Care Medicine and specialty associations.
- 4.7** Training is delivered by departments of anaesthesia working within a school of anaesthesia. The clinical directorate for anaesthesia within each hospital is responsible for delivering in-service training in accordance with curricula developed by the RCoA and agreed by PMETB. The educational facilities, infrastructure and leadership must be adequate to deliver the approved curriculum.
- 4.8** 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.
- 4.9** All staff, including trainees and locums, must be supported to acquire the necessary skills and experience through induction, effective educational supervision, an appropriate workload, and time to learn.
- 4.10** Every trainee must at all times be responsible to a consultant.
- 4.11** Every trainee must have a named Educational Supervisor.
- 4.12** Regular trainee assessment and appraisal are essential. These are performed by the consultant staff and Educational Supervisors and usually led by the College Tutor. Appropriate time and administrative resources must be allocated for this.
- 4.13** The teaching and acquisition of technical anaesthetic skills takes time, and teaching lists may need to take this into account when scheduling surgical throughput.

The College Tutor

- 4.14** Training is led by Royal College of Anaesthetists appointed Tutors (CTs) who are responsible for the training and assessment arrangements in their hospitals. It is not expected that the CT will deliver personally all aspects of training and supervision, but rather that the CT will ensure that training is

properly organised, delivered and accessible by the trainees. It is not a requirement from the College for CTs to take responsibility for the recruitment of trainees.²¹

- 4.15** Many of the responsibilities of the CT underpin clinical governance and clinical risk management in the trust to the benefit of the entire organisation. Adequate time and administrative resources must be allocated within the job plan of the College Tutor.
- 4.16** CTs must be trained in the techniques of appraisal and assessment.
- 4.17** While the day-to-day responsibility for training rests with the CT, the quality of trainees' clinical work is the responsibility of the clinical director.

Consultant and SAS/Specialty Doctor trainers

- 4.18** Clinical supervision, training and workplace-based assessment must be provided by consultants or SAS/Specialty Doctor grades within the department of anaesthesia who are recognised RCoA trainers.
- 4.19** Those involved in training must take necessary steps to acquire the skills of a competent teacher, and maintain their CPD requirements for the appraisal process and to the satisfaction of PMETB and the RCoA.

Other teaching arrangements

- 4.20** All departments of anaesthesia must organise programmes of educational activities. These will include lectures and tutorials on relevant topics, meetings and seminars on such matters as mortality and morbidity, critical incident reporting, clinical audit, research and journal review clubs. Interdisciplinary meetings should be organised where appropriate.
- 4.21** Instruction of foundation year doctors in the pre-operative preparation of patients for surgery, resuscitation techniques and basic critical care principles is commonly undertaken by departments of anaesthesia. Departments are also often involved in training of medical students in the principles of anaesthesia and resuscitation, and basic clinical skills, including fluid management and pain relief. Adequate time needs to be allocated to those arranging such training.
- 4.22** Anaesthetists provide a wide range of training for non-medical hospital staff, including nurses, midwives, anaesthetic assistants and paramedics. For those anaesthetists who undertake such teaching, adequate time for preparation and delivery is essential.

- 4.23** All hospital staff and those in clinical contact with patients must be trained in at least basic resuscitation skills, so that the initiation of resuscitation is not unduly delayed while awaiting the arrival of staff trained in advanced life support. Such training has to be repeated at predefined intervals. Resuscitation training officers should supervise this process.

5 Research and audit

Research

- 5.1** Innovation and improvement in anaesthetic practice for the benefit of patients are facilitated by research. Audits and similar practices cannot replace the fundamental purposes of research, which requires sufficient time and resources. All areas of practice should have opportunities to further their research aims.
- 5.2** An understanding of the scientific basis of anaesthetic practice is essential for all anaesthetists and research is regarded by the RCoA as integral to the development of anaesthesia, intensive care and pain management. Trainees from intermediate level onwards require experience in research methods. Even if separate time is not allocated, the concepts identified in the CCT should be fundamental to the education of trainees at these stages of training.¹⁷
- 5.3** All research must be managed in accordance with the Department of Health Research Governance Framework and research governance requirements of their employing organisation. Anaesthetists must comply with the GMC guidance 'Good Practice in Research'.¹

Audit

- 5.4** All doctors must take part in regular systematic audit and departments of anaesthesia must support this.^{1,12}
- 5.5** All consultants should participate as required in the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and the Confidential Enquiry into Maternal and Child Health (CEMACH) and Royal College of Anaesthetists National Audit projects.
- 5.6** Audit of all areas of anaesthetic practice requires time and incurs a financial cost, for which a budget is necessary. It should include critical incident reporting, risk management and outcome measures.
- 5.7** Hospital data collection systems are an essential support tool in providing the information required

for audit, and must be in place and regularly updated to the highest standards of current technology.

- 5.8 The RCoA's audit 'recipes' provide templates to plan audit programmes.³²
- 5.9 As part of audit, patients' attitudes and comments about the anaesthetic service should be sought.

6 Organisation and administration

- 6.1 Every department should have a written policy in place that takes account of local circumstances to ensure the effective and economic use of anaesthetic resources in terms of:
 - staffing
 - equipment
 - consumables such as drugs and disposable devices.

Lead clinicians in anaesthesia

- 6.2 Departments of anaesthesia must have a clinical services director (CSD), head of department or lead clinician who is an anaesthetist.
- 6.3 The lead clinician or CSD is accountable to the chief executive but cannot function without the support of consultant and other colleagues and must therefore be acceptable to them.
- 6.4 The lead clinician or CSD is responsible for staff management, including management of leave, job planning, management of poorly performing doctors and equitable distribution of work within the department sufficient to cover the service. They are also responsible for ensuring adequate resources, maintaining good communication, both within the department and between the department of anaesthesia and the wider trust network, and ensuring guidelines are in place and regularly reviewed.
- 6.5 The lead clinician or CSD should be supported by and work closely with business and nurse managers as well as have ready access to specialist managers in such areas as finance and human resources.
- 6.6 The lead clinicians or CSD should have a separate contract for this part of their work, working with an agreed job description. Adequate time must be available and they should receive appropriate administrative and information technology support to fulfil their roles effectively for the trust.
- 6.7 Named consultants should also be appointed who are responsible for the individual components of the service, such as critical care, obstetric anaesthesia, acute and non-acute pain services,

paediatrics and day surgery. Lead clinicians for these components of the anaesthetic service should ensure that communication is managed in a way that meets the needs of appropriate confidentiality, protects the needs of patients and maintains the efficiency of the overall service.

- 6.8 Other essential roles that may need further delegation within the department of anaesthesia include pre-operative assessment, major incident planning, rostering and management of leave, equipment, information technology, audit, clinical governance, transfusion, continuing medical education and professional development and training.

Theatre efficiency

- 6.9 The organisation of theatre services must match the needs of patients and take into account availability of surgeons, anaesthetists, nurses and paramedical staff. This will include 24-hour availability of an emergency theatre service to minimise the need to use out-of-hours services for situations other than true emergency surgery.
- 6.10 Those managing the anaesthetic service should co-operate and communicate with surgical and other directorates to optimise the treatment of patients and encourage best use of available facilities.
- 6.11 Optimal theatre efficiency may be facilitated with the support of appropriate planning and management, diagnostic tools, information technology, human resources and service redesign, and implemented by a Theatre Management Group. Anaesthetists must play a key role in this process, to ensure clear communication between all the managerial and clinical staff involved in daily running of theatres.^{33,34}

Human resources, job planning and staff management

- 6.12 All consultant and associate specialists and specialty doctors must participate in job planning.^{12,28,34,35}
- 6.13 All doctors must undertake an annual appraisal.^{1,12,30}
- 6.14 A number of anaesthetists also undertake local, regional and national duties in the fields of education, research and administration. This may occasionally involve them being away from their clinical duties on periods of professional leave. Such activities have the mutual benefit of forming part of CPD and attracting recognition for the employing trust. These activities should be reflected in job planning and appropriate staffing levels.

7 Patient information

- 7.1** Patients have a right to information about their condition and the treatment options available to them, and all doctors have a duty to inform patients in sufficient detail about these options.¹
- 7.2** Patients should be provided with adequate information about anaesthesia, pain relief and any other services provided by anaesthetists so that they can make informed decisions about their treatment and care. Patients should be given adequate time to consider the options available to them and make appropriate decisions about their care. However information is conveyed, it is a duty of the anaesthetist administering the anaesthetic to explain what is proposed in order to satisfy the requirements for informed consent to anaesthesia.
- 7.3** Leaflets and internet-based material produced by the Joint Patient Information Project of the RCoA and the AAGBI may be offered to patients who are to undergo anaesthesia.³⁶

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