NAP 8 Local Co-Ordinator Webinar **24th November 2025**

Question and Answer section

When will posters and slide sets be available?
We plan to distribute before Christmas with a view to promoting the main case registry during January/February. Provisional launch of the case registry is March 2026 with the activity survey being planned for June 2026.

In Ireland, we aren't generally members of the RCoA. Is there a separate link for Irish colleagues to log into the The Royal College website?
You don't need to be a member of the Royal College website to access the NAP8 section of the RCoA website.

Is there a deadline for letting college know about local coordinators?
There is no formal date but given we are aiming to start the case registry in March we need local co-ordinators in place prior to that as well as time to seek Caldicott approval for that Trust/Health board (in England, Wales and Scotland).

What if the Associate Local Co-Ordinator is not going to be based at the same hospital for 12-18 months?
We recognise that residents, specialty or locally employed doctors may not be in the same place for 18 months. The scheme is new but hopefully if you move from one hospital the Associate LC can keep their role and help at the new hospital and likewise someone else might come to a hospital having already been an Associate LC elsewhere. If an Associate LC leaves but no one else comes in from a different hospital then it would be appropriate to advertise for more Associate LC positions depending on need.

Are there letters for recognising the role?
Yes letter of recognition will be arranged. All LCs and Associate LCs will also be listed as collaborators (i.e. PubMed citable) on relevant publications at that stage.

Limiting the Associate Local Co-Ordinators to stage two and stage three isn't practical outside of tertiary centres. Can Stage 1 (or equivalent) resident doctors be appointed to the Associate LC role.
The steering group has both RAFT and SAS representatives who helped set the initial criteria. However following the webinar we have discussed this and we have changed Stage 2 and 3 residents (or equivalent) from 'essential' to 'desirable' in the person spec document. Therefore if a LC feels that, depending on local circumstances, a more junior resident, specialty or locally employed doctor is appropriate then this is now OK.

It looks like we may need to take some professional leave, non-clinical time during the June activity phase week. Any idea what the dates will be?

We will try to arrange dates as soon as possible and let everyone know. The June activity survey is contingent on launching as outlined earlier in March which in turn depends on the case registry being built and all Caldicott Guardians in place (which we are obviously working on at present).

Are we looking at nerve injury secondary to supraglottic airway insertion?
The local co-ordinator document has all the inclusion and exclusion criteria but in short no this is not something we will study in NAP8 under the remit of perioperative nerve injury.

I can imagine patients who have a peripheral nerve injury persisting at six months would be pursuing medical legal action, so we can't contact them?
This is correct. NAP8 should not change clinical practice so in general no patient should be contacted just for NAP8 purposes. Any patient with a nerve injury should be followed up as per standard local practice. Nerve injuries that present should be managed locally and logged in the NAP8 case registry at the time of presentation. The reporter's email will then be held anonymously by the webtool and an email will be sent at 6 months prompting further information (after which the email will be deleted). We accept at 6 months there is a possibility all the investigations will not be complete or information may not be available but we have to be pragmatic about how long we can keep the case registry open. Based on the advice from our peripheral nerve surgeon on the steering panel we are defining nerve injuries as permanent if symptoms are present at 6 months (at that point any injury is unlikely to completely resolve).

Are we looking to report also nerve injuries due to surgery?
Not if directly due to surgical injury. We are looking however to collect information on positioning and tourniquet related perioperative nerve injuries. Studies suggest the rate of direct surgical nerve injury is much higher than that due to regional anesthesia (or other perioperative nerve injuries) and so these injuries are beyond the scope of NAP8. There will definitely be difficulties in picking apart some injuries in terms of whether it is block or surgery related because clearly we (the NAP8 team) are looking at anonymous reports and cannot access patient notes. We are therefore relying on LCs and the reporting anaesthetists to fill out or case registry forms as accurately as possible to help us decide but despite this there will still be a number we are unable to determine and will need to report as such.

Can we clarify all cases where surgeons, other operators, perform blocks autonomously, where the patient is not normally under care?
If the patient has not been under the case of an anaesthetist then this is correct – these patients do not meet the inclusion criteria (this includes emergency physicians also).

Will NAP8 investigate differences in nerve injury for blocks performed while awake versus under GA?

So yes our activity survey will collect this information to give us an estimate of blocks done awake versus asleep and likewise this will be asked about for any nerve injuries that present to the case registry. Whether we get enough data to answer that question remains to be seen however. Similarly we will look at needle size, BMI, ultrasound, co-morbidities, age and obstetrics/pain/perioperative and other factors also.

Nerve injury cases related to central neuraxial blocks and peripheral nerve blocks will not necessarily be reported to anesthesiologists. But how can we collect data on non-regional anesthesia related nerve or spinal cord injury which are not directly related to anesthesia?
This is where we are relying on LCs to promote NAP8 amongst your surgical colleagues, local neurologists and other allied health care professionals like physiotherapists where patients may present post-operatively. We will provide material and a structure to help with this in the New Year.

Are we including continuous nerve block related equipment like catheter dislodgement.
No we will not be picking apart manufacturer data for different equipment. Catheter dislodgement whist not good is not a major complication and will not be studied.

My hospital is exclusively for obstetric anesthesia and complications would be referred to the Neurocentre at the Walton, Liverpool.
If the neurocentre presumably has anaesthetists then it will be taking part in NAP8. So yes there is a risk of duplication if a complication presents to a different hospital. We would obviously expect in such cases the team who initially did the neuraxial block to be aware of this given the referral to the neurosurgical centre. For NAP8 we would ask that you communicate between the two centres before submitting a case to avoid duplication. This relates also to any complication that may present to the NHS if the case was undertaken in the independent sector. There will be a box for this on the case registry i.e. 'did the complication present to a different hospital from where the original anaesthetic took place'?

Do we collect TAP blocks, pudendal blocks etc by surgeons?
Yes if an anaesthetist is there. Yes also for surgical local anaesthetic infiltration if an anaesthetist has been involved.

From what I understand, we do not contact patients directly at any point. It should be through the primary clinician and follow up.
Yes that's correct. Patients do not consent to take part and NAP8 is all anonymous, so all patients are only followed up as per standard local processes.

I can see at my place there's just one local coordinator. Do I need another to help?
It is up to you to decide on the size of your hospital and how many sites there are and how many LCs you need. For example at my hospital we have our main hospital and a standalone ambulatory hospital on a separate site plus a large obstetric unit so we have

three LCs. Ultimately it is up to you and your local Clinical Director to decide if you think you need more than one LC based on number of sites and size of your theatre complex(es). As discussed earlier Associate LCs can also be recruited to help.

Any suggestions for how to encourage surgical colleagues to let local coordinators know which don't relate to regional anesthesia?
We are not collecting direct surgical injuries but yes if it is positioning related injuries we have shared responsibility. As before we need LCs to promote the project amongst all our surgical colleagues in order to have these injuries fed back to us and logged in the case registry.

I have just got on board as a LC but it's not been updated on the RCoA website.
Due to staff sickness we are still catching up with this so please allow us a few weeks to catch up with the website but please contact us at the NAP8 email address if it is still not done in the next few weeks.

Would it be possible to have a summary of the questions and answers?
Yes this will be done (this document!) and likewise the recorded webinar will be available for catch up.

We do lots of hand surgery for trauma patients, traumatic nerve injuries. They've had an axillary block. How do we differentiate?
The case registry will guide you through various questions such as the location of symptoms, the exact surgical procedure and all relevant questions. We will not ask you for the specific nerve roots you think are involved but rather just the areas and then it will be up to the multidisciplinary group to assess the information (we will however ask for your opinion also along with that of the local multidisciplinary team!) Some cases will no doubt have to be reported as indeterminate however as we will be unable to determine causality.

So to clarify, we are including surgical nerve ranges due to positioning and stretch, but not the knife.
Yes essentially! Plus tourniquet related injuries.

Do we need to check if any patients have opted out of having their data collected?
We are not collecting confidential or identifiable patient information so NAP8 falls outside the remit of the national data opt out. So the answer is no.

What about the patients who present with chronic post-surgical pain?
If it's due to a nerve injury due to regional anesthesia or the other causes of nerve injury we've discussed, then yes.

Do we need to look into local anesthetic anesthesia, infiltration by surgeon or nerve catheters inserted by the surgeon?
Yes if these cases have occurred with an anaesthetist present. And yes if there is a complication we want to know about it if an anaesthetist has been present.

PIEB for labour, epidurals, high volume delayed wear off, one sided weakness which resolves – is that a complication?
No that is not on our inclusion list as a major complication if this is simply linked to the duration of the local anaesthetic.

Do you need to document any neuropathic symptoms in diabetic patients?
Nothing different should be documented pre-operatively beyond standard practice. Certainly if a patient has pre-existing neuropathy (or diabetes) this is one of the co-morbidities we are collecting in the activity survey. If a patient presents post-operatively with a new nerve injury pre-existing neuropathy again (along with diabetes) will be being asked about in the case registry.

If at six months time the patient has been followed up but the next appointment is a few months away and we don't know whether it's resolved what do we do?
Yes you have to just wait for the appointment to happen and log as 'don't know' at 6 months. We would not be able to classify as permanent at 6 months but we cannot keep the database open for such cases as we have to be consistent and the follow up period as previously noted has been set at 6 months.

Severe PDPH requiring several blood patches?
No. Whilst clearly distressing and disabling for patients this is arguably too common for NAP and so unless the patient has for example some other rare nerve injury after a PDPH, then no this is not to be reported.

How many associate local coordinators?
We are suggesting as a starter a similar number to the number of LCs but it is ultimately a local decision based on the size and geography of your hospital(s).

Lots of neck of femur patients come in with a fascia block in ED and then we also provide a block during surgery if there's a nerve injury.
Yes it is possible we might not be able to differentiate. Everything will be logged in the case registry and we can make an assessment.

The standard practice in our hospital is to follow up patients who receive certain blocks by a phone call.
If you are following patients up already please continue to do so.

The process of selecting the associate trainee, should it be through an interview process?

We have provided a scoring system and essential/desirable criteria which will be shared with all applicants. As long as the appointment process is fair and transparent then it is up to the LCs. It may be that you score everyone and just interview a select top few or you appoint on scores alone.

Is it worth asking if they're all colleges or surgeons to publicize? Yes. So the RCS are one of the partners, so we're working on promoting it amongst all these organisations.
Some of my patients might have had a central neuraxial block but they may develop peroneal nerve injury due to positioning.
Yes, that would get reported because that's a nerve injury that's not due to a direct surgical injury. Likewise any other peripheral nerve injury due to lithotomy should be reported.