Preparing your College to meet the challenges of the next 25 years

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Happy New Year.

I hope you enjoy the new look, punchier Bulletin. Please share your views in a Bulletin article (see ‘Coffee Room Rants’ by George Collee and JP Lomas for alternative outlets).

In this edition of the Bulletin, President Liam Brennan gives an update on the College’s governance review and the proposal that we appoint lay trustees to enhance and complement the expertise of our existing Council. Vice-President Ravi Mahajan shares his views on the impact of new care models on the anaesthetic workforce. Iain Moppett, newly appointed Deputy Director of the Health Services Research Centre thinks ‘Big’ (tickets and data). Ollie Boney explains ‘cultural appropriation’. Rob Thompson, chair of the Lay Committee, reminds us that there is extensive evidence that the anaesthetist’s communication skills are key to patient satisfaction.

Undergraduate training, leadership and management, climbing Everest, cycling the Andes, new national safety standards for invasive procedures, time out as a management consultant, a view from down-under and more! If you are looking for new challenges or pondering your resolutions there are no shortage of ideas.

‘Myth tells us what we could have been. In this century the most influential mythmakers have been moviemakers.’ Dr David Zuck penned this for his regular ‘As We Were...’ column shortly before he passed away in November last year. The College is enormously grateful to David. He faithfully delivered a regular column for the Bulletin since he was first invited to do so in 2001, he was a past President of the History of Anaesthesia Society, and had received a President’s Commendation.
PREPARING YOUR COLLEGE TO MEET THE CHALLENGES OF THE NEXT 25 YEARS

The President’s view
Our 25th anniversary is not only a time for celebration, but also an opportunity to reflect on all aspects of how we conduct the business of the College.

In last June’s edition of the Bulletin I outlined our first ever five-year strategy, which Council and I hope will keep us on the road to continued success. Achieving our strategic goals will require transparent and robust systems to maintain our focus and ensure that we work effectively. This is the essence of the good governance that is essential to the future security and prosperity of a membership and charitable organisation such as the College.

Our governance structure has not been scrutinised thoroughly since the granting of our Royal Charter in 1992. During that time our College has grown enormously and is now a medium-sized business employing nearly 100 staff, with an annual income of over £12 million and total assets, including our headquarters in Red Lion Square in London, of over £40 million. All this has been achieved with one of the lowest fellowship fees of any Royal College.

Although our current systems have stood the test of time, there is no room for complacency. For example, the recent events at Kids Company have brought into sharp focus the potential for a charitable organisation to lose sight of financial governance, with disastrous consequences. Furthermore, recent economic forecasts suggest that we are facing uncertain times, with a flat economy or worse in the medium term.
Many organisations are re-examining their governance arrangements, including many of our own peer group of medical Royal Colleges. Against this background, Council have established a Governance Review Group to examine all aspects of our governance. This article is the first in a series of updates on the work of the governance review, and this work will culminate in proposals being brought to the Annual General Meeting in March 2018 for the consideration of the entire College membership.

Who are the members of the Governance Review Group?
The review group consists of 15 members from within and outside of Council who are representative of the College’s membership and stakeholder groups. Rob Thompson, the current chair of the College’s Lay Committee and a former hospital chief executive, leads the group. We have also included a member from the wider College membership, Paul McAndrew, who was chosen after an open selection process. Paul is a consultant practising in Sunderland who has never held any College appointment and is currently a Deputy Medical Director in his trust. In attendance, besides members of our own senior management team, are representatives from two external bodies. Firstly, Andy Friedman, CEO of the Professional Associations Research Network (PARN). PARN is a not-for-profit organisation for professional bodies that facilitates the sharing of expertise and best practice on key issues including governance.

What areas are the review group considering?
The work of the Governance Review Group has been divided into five work streams:

Trustee board structure
The RCoA, as a charity, is run by its trustees. Currently, they are the 24 elected members of Council, whose duties are outlined in a number of documents published by the Charity Commission:
- to ensure that the charity is carrying out its purposes for public benefit
- to act in the charity’s best interests
- to act with reasonable care and skill
- to comply with the charity’s governing document and the law
- to manage the charity’s resources responsibly, including assessing and managing the charity’s risks
- to ensure the charity is accountable, by demonstrating that the charity complies with the law, is well run and effective, and shows accountability when tasks are delegated to staff.

There is little doubt that Council fulfils the first three of these duties well. However, as the College increases in size and complexity there is a need to ensure that elected Council members are equipped to meet the last three of these responsibilities. Many of these duties relate to managing the College as a business, particularly in relation to the financial, resource, employment, IT, legal and risk management aspects of the organisation. This skill-set is not the remit of the majority of clinicians who stand for election to Council.

As the College has flourished up until now, it is tempting to believe that there is no need to change. However, given the current scale of transformation in the College and the wider NHS, we must be confident that we are as prepared as we possibly can be and are fit for purpose in the long term. Although we employ highly competent senior staff to deliver our strategy, an over-reliance on them creates the potential for unacceptable risks to the charity, the trustees and the staff themselves.

Council are actively considering, in line with nearly all our peer-group of Royal Colleges, that the way to mitigate these risks is to recommend that we appoint lay trustees to enhance and complement the expertise of our existing Council.

The details are yet to be fleshed out, but trustees with experience in running a large business, a high level of financial literacy, legal expertise and an HR background may be some of the areas we would wish to consider.

ACHIEVING OUR STRATEGIC GOALS WILL REQUIRE TRANSPARENT AND ROBUST SYSTEMS TO MAINTAIN OUR FOCUS AND ENSURE THAT WE WORK EFFECTIVELY
This would free up more time for Council to have in-depth strategic discussions, rather than focusing on operational issues.

Reporting processes to Council
The College is committed to transparency and demonstrates this by publishing comprehensive minutes of Council meetings on our website. However, anyone who has looked at those minutes would confirm that at present reporting structures to Council are not necessarily aligned to the RCoA strategy. Due to the large number of committees, Council discusses little detail of their proceedings, much of which is highly technical, e.g. training and examinations.

Council are considering setting up new Boards to oversee each of our strategy’s four themes. These Boards would oversee the work of the existing College committees, working parties, working groups, etc., which currently number over 70, and determine what needs to be raised at Council for approval, further discussion or information. This would free up more time for Council to have in-depth strategic discussions, rather than focusing on operational issues.

This restructuring will also allow the current committees and groups to align with the relevant Board, directorate and RCoA strategy. An important part of each Board’s work will be to consider the committees and groups that fall within their remit, and decide if they are continuing to contribute to the College’s overarching strategy. If they don’t, then do they need to continue or can they be wound up or merged to rationalise the use of resources, including clinicians’ valuable time?

Aligning our devolved nation Boards
In Scotland, Wales and Northern Ireland the College has a Board for each nation which considers specialty and wider professional issues as they relate to each of the devolved nations. The membership, terms of reference (ToR) and resourcing of these boards have developed organically over many years. We plan to create a more streamlined approach to our devolved nation work, with a unified ToR, while still allowing some flexibility and acknowledging country-specific issues that must be accommodated.

Aligning our Faculties within the College
The main focus of this workstream is revisiting the regulations of the Faculty of Pain Medicine (FPM) and the Faculty of Intensive Care Medicine (FICM), while retaining harmony with any changes we make to the College regulations. FICM requires careful consideration. Unlike FPM, who are fully incorporated within the RCoA, FICM is a faculty – now with over 3,000 members – aligned with seven other Colleges but hosted within the RCoA. For example, the College manages finances on FICM’s behalf but there is no current provision to generate a reserve for FICM that can be used either to counter future risks or to take advantage of potential opportunities in a timely fashion.

Scheme of delegation
A fundamental principle of good governance for any charity is delegated authority. A Scheme of Delegation sets out the authority delegated by Council to the College officers, Boards, chief executive and other members of the senior management team, to facilitate fully accountable, effective and efficient management of the charity. Many aspects of these requirements are in place but the governance review is timely, allowing us to ensure uniformity of approach across all the College’s work in this crucial area of governance.

I hope you are reassured that in conducting this governance review, Council and I are future-proofing your College to meet the challenges of an increasingly uncertain world. I will keep you in touch with developments over the course of 2017 before we bring our final recommendations to the College AGM in March 2018.

If you have any comments or queries on this or any other issues, I would be pleased to hear from you at presidentnews@rcoa.ac.uk

References
1. The RCoA Strategic Plan 2016-2021 (www.rcoa.ac.uk/node/23418).
News in brief
News and information from around the College

Devolved nation newsletters
Complementing the monthly RCoA President’s Newsletter (http://bit.ly/2q2Dyn8), the College is now increasing our interaction with members within each of the devolved nations through dedicated newsletters and other engagement initiatives. The first quarterly nation-specific newsletters have been received by fellows and members in Scotland and Northern Ireland. Members in Wales will receive their newsletter later this month. These newsletter updates build on the initiatives from within RCoA’s five-year strategy (http:/ /bit.ly/2aFL7yR) aimed at supporting anaesthetists throughout their career, setting and maintaining the highest standards and promoting anaesthesia by engaging members and informing the public.

With developing member engagement and the College’s wider communications a top priority for Council, these newsletters are a new platform through which anaesthetists in all devolved nations are able to address issues of specific relevance to their local regions. The College is keen to be more accessible to all members and this new platform will assist in improving two-way communication with fellows and members throughout the four home nations.

Visit our 25th Anniversary website for information on all our planned activities
WWW.RCOA.AC.UK/RCOA25

Council and elections update
It has been election season at the College over the last few months, with ballots open for places on Council as well as the RCoA Scottish Advisory Board.

The Council ballot closed on 5 December so as you read this edition of the Bulletin, the names of those joining in March 2017 will have been decided by fellows’ votes. Check the RCoA website to see who will be taking up the three consultant positions and one trainee post on College Council. Results will also be published in the March issue of the Bulletin.

The RCoA had also invited applications for one consultant vacancy and one SAS vacancy on the Scottish Advisory Board with nominations closing on 1 December. You can also check the status of this on the College website and we will provide an update for members in the March issue of the Bulletin.

If you have any questions about College elections please contact ceo@rcoa.ac.uk.
Consultation responses

Recognising the importance of contributing to external consultations to influence good practice and contribute to wider healthcare discussions, the RCoA responds to a variety of consultations from various health organisations and government bodies. On average the College issues 70 responses to consultations per year, ranging from consultations on specific clinical topics from specialist societies to comments on wider healthcare policy proposals from the Department of Health.

Over the last few months the College has contributed to several significant consultations, including commenting on the House of Commons inquiry on the implications of Brexit for health and social care, and providing a consultation response to the revised Never Events Framework by NHS Improvement. With the work of anaesthetists crossing many boundaries, the RCoA’s recent response to the House of Lords Select Committee inquiry on the long-term sustainability of the NHS reflected the specialty’s unique position in being able to see the big picture and having a broad understanding of healthcare delivery.

October and November 2016 consultation responses can be found on page 74. For more information and to read the latest RCoA consultation responses, visit the College website: http://bit.ly/2flqskN.

FRCA examinations update

The RCoA’s examinations have evolved over time to reflect best educational and assessment practice as well as developments in anaesthesia, intensive care and pain medicine. Recent examination pass rates continue to show encouraging signs of improvement. The Primary OSCE/SOE examination, which was held on the week commencing 7 November, was attended by over 360 candidates with an overall pass rate of 64%. This directly compares with the 64% pass rate recorded at the May exam, which was the highest pass rate recorded for the Primary OSCE/SOE since 2009.

The pass rate for the Final Written examination in September 2016 was 71%; a significant increase on the 35% pass rate at the examination last year. As we progress further into the current academic year with the next Final Written examination on 7 March 2017, the recent results represent extremely positive news. A number of factors will have contributed to the recent rise in pass rates. Aided by the dedicated support of their trainers, anaesthetists in training have remained admirably focussed on exam preparation despite the uncertain backdrop. The many resources provided by the College, including Primary and Final Masterclasses, exam videos and our e-Learning Anaesthesia platform will have made a difference, as well as the provision of a consistently well-run and highly-organised exam, ensuring that candidates are not unsettled on the day. For more on the FRCA Examinations, including information on the syllabus, regulations and candidate resources, visit the RCoA online exams page (www.rcoa.ac.uk/examinations).

Notice of Annual General Meeting

The 2017 Annual General Meeting of the Royal College of Anaesthetists will be held as follows:
Thursday 9 March 2017 at 10.50am at Puddle Dock, Mermaid Conference and Events Centre, Puddle Dock, Blackfriars, London, EC4V 3DB.

As in recent years this meeting takes place as part of the annual Anniversary Meeting. This year’s theme is Landmarks in UK Anaesthesia.

Further details can be found at www.rcoa.ac.uk/anniversary

If you wish to attend the AGM and not the meeting please email ceo@rcoa.ac.uk
Research and QI update

The RCoA is committed to delivering world-class research to better improve anaesthetic practice and patient outcomes. With a number of important research projects underway, the College will soon be reaching significant milestones in the development and data collection processes of various large scale studies.

With the reporting period for the College’s 6th National Audit Project, examining perioperative anaphylaxis, having ended on 4 November, cases occurring beyond this date will not be included in the final report, but all cases occurring up to this date should be reported by local co-ordinators. Many thanks also to all who took part in the recent NAP6 Organisational Survey. See more at www.nationalauditprojects.org.uk, and submit queries to nap6@rcoa.ac.uk.

National Emergency Laparotomy Audit

The Second Patient Report of the National Emergency Laparotomy Audit was published in July 2016 and is available at www.nela.org.uk/reports.

On 30 November the third year of NELA data collection ended, with data collection for year four having started on 1 December.

Work is ongoing with NELA local leads to log all cases for the year three reporting period, but any queries can be submitted to info@nela.org.uk.

PQIP (Perioperative Quality Improvement Programme)

PQIP (Perioperative Quality Improvement Programme), a multidisciplinary initiative supporting local quality improvement to benefit patients undergoing major surgery, launched on 7 November 2016. Sites will only begin collecting PQIP data as and when they are able and once all the relevant regulatory paperwork is completed. If your hospital wishes to take part in PQIP please contact pqip@rcoa.ac.uk. More information on the programme can be found at www.pqip.org.uk.

The 2nd Sprint National Anaesthesia Project (SNAP-2)

The 2nd Sprint National Anaesthesia Project (SNAP-2) will examine the epidemiology of critical care provision after surgery and whether planned postoperative critical care admission is effective as an intervention to reduce postoperative morbidity.

It will launch in March 2017 and local SNAP-1 investigators are being contacted to confirm participation in SNAP-2. If you were involved with SNAP-1 and have not yet heard from us, please do get in touch by contacting snap2@rcoa.ac.uk.

Further information can be found at http://bit.ly/2q7o551.
Workforce data pack

The RCoA has published a new workforce data pack (http://bit.ly/2gqaYNj), which provides anaesthetic workforce information collated from sources including the College’s Medical Workforce Census 2015 (www.rcoa.ac.uk/census2015), the Centre for Workforce Intelligence’s review of anaesthetics and intensive care medicine, the National Recruitment Office and various other sources.

The pack provides members with up-to-date information on the current anaesthetic workforce in the UK. The document outlines the issues and pressures affecting the specialty that impact on the anaesthetic workforce and will be used to feed into Health Education England’s review process. Information within the pack can be used locally in regional meetings and the workforce data can be shared with your school and local workforce planners. If you are experiencing local workforce issues, inform the College by emailing training@rcoa.ac.uk.

What is the RCoA Fellows and Members Room for?

The RCoA Fellows and Members Room offers an accessible place for fellows and members to meet and collaborate whenever they are in London. It features Wi-Fi and desks with charging points to enable fellows and members to work.

Where can I find it?

The Fellows and Members Room is located on the second floor at the RCoA. The room was recently renovated and now offers seating for informal meetings as well as tea and coffee making facilities.

Can I turn up any time?

The College is open between 7.30am and 6.20pm and fellows and members are welcome to use the room between these hours. Upon arrival, please inform reception that you are a fellow or member of the College and you will be given directions to the room.
The world, no doubt, is undergoing massive shifts in population dynamics and population health. Only two decades ago, patients presenting to GP clinics or hospitals were relatively younger, would have predominantly single morbidity, and required relatively straightforward interventions. With more people living longer, paralleled with advances in medicine, we now face large number of our patients who are elderly, have more than one co-morbidity, undergo complex treatment regimens, require multispecialty input and make increasing demands on social and community care. However, the way we are training our workforce has largely remained traditionally disease focused and specialty oriented. Although the workforce is continually adapting to the changing population health, the question that we face is whether or not the workforce will still be fit for purpose over the next 20 years.

There is growing realisation that future healthcare delivery will require a shift from the current system of managing patients through multiple episodes at primary, secondary and/or tertiary care centres, to an integrated, without-boundary approach of seamless, individualised care that will involve primary and acute care, specialist input, and enhanced health in care homes and multispecialty community providers. This shift in healthcare delivery will certainly have implications for the present and future workforce. In order to pre-empt and be ready for the shift in healthcare models, the present medical workforce will require re-shaping. The traditional paradigms of focus on disease and specialty will benefit from some added dimensions. The added dimensions will come from realisation and understanding of the workforce requirements in terms of capacity, capability and collaboration. For the medical workforce, we will undoubtedly need more doctors (capacity). Importantly, they will need to be equipped with the knowledge and...
skills suited to the changes in population health (capability). Also, the ways of delivering integrated healthcare will not be possible without collaboration among different specialties.

This year, NHS England have launched 50 ‘Vanguards’ for the New Care Models programme. These Vanguards will be leading on the development of blueprints for the new care models for the future. The overall aim of this initiative is to re-design the workforce across organisational and professional boundaries, to help resolve long-term tensions and deliver the care that the population requires. In addition, the staff will have more opportunities to develop. The population will inevitably have different levels of needs – public health for the whole population, and urgent care, ongoing care and increasing dependency care for different proportions of the population. A comprehensive, joint, strategic analysis of these needs is urgently required. This will then allow policy to address the issues related to workforce capacity, capability and collaboration. The question ‘Do we have enough staff?’ will lead to addressing training numbers and supply. An assessment of whether or not our workforce has the right competencies and skills will allow development and education programmes. And finally, a need for collaboration and integration will require the right culture and behaviours facilitated through opportunities for reflection, training and developing together.

The RCoA has been extremely proactive in realising the requirement for a shift in our paradigm of anaesthesia services. The vision and implementation of Perioperative Medicine is an excellent example of how the healthcare needs of an individual undergoing surgery can be integrated between and within primary and acute care, alongside addressing the needs for social care. Perioperative medicine offers us great opportunities to lead on New Care Models as initiated by NHS England. As anaesthetists, we are certainly most capable in our ability to deliver perioperative care. We will require more strategic thinking around our capacity and ways of collaboration.

Implementation of perioperative pathways is already taking shape in different parts of the UK. Modest changes have been made to the curriculum for training, and various departments now offer advanced training modules for perioperative medicine. Some local initiatives that have embraced the concept of perioperative medicine are already in progress. These initiatives will allow us to analyse any capacity and collaborative requirements and tensions. Also, we will need better cross-communication to learn from how some leaders have successfully found solutions to emerging and seemingly difficult issues.

Good and effective leadership, locally and nationally, is going to be the key to successful implementation of any new healthcare model. In anaesthesia, it is important that our agenda for perioperative medicine, which is well aligned to NHS England’s thinking on workforce models, keeps momentum with the cycle of implementing evolutionary changes born out of continuous learning. This will require newer ways of evaluating successes (or failures), governance and accountability, harnessing technology, understanding and embracing workforce re-design, and communication and engagement. As the largest hospital-based specialty, we have a tremendous opportunity to take the lead in providing integrated, individualised care for our patients. And we must not let this opportunity go by.

INTEGRATED HEALTHCARE WILL NOT BE POSSIBLE WITHOUT COLLABORATION AMONG DIFFERENT SPECIALTIES
Happy New Year to all! Since the launch of Anaesthesia Clinical Services Accreditation (ACSA) in 2013, we have seen the growth and development of a respected peer-review scheme designed to encourage a partnership between the College and anaesthetic departments throughout the UK.

With 13 departments accredited and a further 84 engaged with the process (numbers correct at the time of writing this article), ACSA has grown steadily.

There have been significant changes to the ACSA standards over the past few years, with paediatrics being included within the main body (domains 1–4). We have used the annual standards review to try to reduce duplication and improve clarity in a number of areas where standards appeared ambiguous and difficult to evidence.

We held our first regional ACSA event at St Helens & Knowsley NHS Trust in 2016. We have been asked to speak at a number of regional and departmental governance meetings and at trust-wide patient-safety events. These meetings have been valuable to us and have hopefully proven useful both to those already engaged and to those considering adopting ACSA within their departments.

So what do the next few years have in store? In 2017 the focus of the College team is to develop an ACSA IT platform.

This will enable accredited or engaged departments to sign into the ACSA programme, view their progress via a dashboard, fully access the Good Practice Library of standards, and source event information, all at a click of a button.

Outside of the College, accreditation is certainly a great topic of conversation. November saw the launch of the Clinical Services Accreditation Alliance (CSAA) workstreams, with a formal ACSA presentation as part of the launch event. The College is a member of this alliance and has been involved with the development of its workstreams and publications.

The future work of the CSAA will be supported by the Health Quality Improvement Partnership (HQIP) and the College will work closely with HQIP and CSAA to support the development of professionally-led and patient-centred clinical accreditation schemes.

For further information on ACSA please visit www.rcoa.ac.uk/acsa, email: ACSA@rcoa.ac.uk or telephone 0207 092 1697.
Every year, we publish a Quality Assurance Report for the Continuing Professional Development (CPD) approval scheme at the College. The latest report, covering the period from 1 November 2015 to 31 October 2016, is available on the CPD section of our website.

Focusing on some headline information from the report:

- details of 1,155 events were submitted to the College (an increase of 138 on the previous 12-month period)
- 86.7% of the submissions were unconditionally approved
- 8.8% were only approved after further information or clarification had been provided; for example, queries on the programme timings or a mini biography requested for the faculty members
- 4.5% of the event applications received were declined for CPD.

The majority of CPD-approved events were being held in London, the North West, the West Midlands, and the South East. Compared with the previous 12-month period, there were more CPD-approved events being held in the South West and in Scotland. In order to maximise promotional opportunities, event providers are strongly encouraged to specify keywords when making an application and also to include a hyperlink to their event information or organisation’s website.

The CPD event evaluations were completed by 76 CPD Assessors, and we are very grateful for their support and expertise in this important role. We welcome applications from those wishing to become additional CPD Assessors, and we have an updated process in place for new appointments.

This year’s report focused strongly on the actions taken by event providers in response to delegate feedback received, and it was encouraging to see lots of examples of good practice. However, there were still some areas for improvement – such as the need for events to have clear learning outcomes, since the ‘Reflection’ element of the CPD process will be based upon these.

For more information about the report, please contact cpd@rcoa.ac.uk
The Faculty of Intensive Care Medicine

The e-learning programme for e-ICM

Dr Pete Hersey
Clinical Lead

Dr Sarah Marsh
Deputy Clinical Lead

The e-learning programme for Intensive Care Medicine (e-ICM) includes approximately 700 high-quality e-learning resources, providing an essential educational resource for anyone working in critical care. It is easily accessible, and activity is recorded as evidence of CPD activity for appraisal. Importantly, it’s completely free for anyone working within the NHS.

The resources themselves take a variety of forms. Most are the kind of sessions you will be used to if you’ve used e-Learning Anaesthesia (e-LA), but there are also review articles and links to relevant guidelines. As well as producing our own original content, we have used the best and most relevant content from 23 existing programmes from within e-Learning for Healthcare, including e-LA. All of the sessions have been peer-reviewed, both for scope and content, before being accepted for inclusion within e-ICM.

The structure of e-ICM is one that you will hopefully find intuitive. The programme is divided into ten modules:

- module 1 is identical to the first module of e-LA. It is written for the trainee undertaking their first six months of training in anaesthesia, and, whether this learning is undertaken via e-ICM or e-LA, the system records the activity in both

- module 2 provides an overview of the general aspects of clinical intensive care medicine that are not specific to a particular disease or patient group, for example organ-support and transfer medicine

- module 3 describes the wide spectrum of diseases that present to a critical care unit. A wide variety of pathologies are presented, classified by medical and surgical specialty

- module 4 details the prevention and treatment of infectious disease within intensive care medicine. This module also covers the common causative pathogens encountered in intensive care medicine

- module 5 is concerned with the management of trauma and traumatic injuries

- module 6 gives a practical overview of common procedures within critical care. It also includes resources to aid in the interpretation of commonly requested investigations, including imaging studies. Monitoring is discussed, both from a general viewpoint but also more specifically

For details of how to access the programme, please visit www.e-icm.org.uk
with regards to monitoring the cardiovascular system and intracranial pressure.

- Module 7 is a basic science module, mirroring e-LA in the same way as module 1.

- Module 8 concerns patient safety. Critical incidents and emergency situations are covered, plus safety in blood transfusion, prescribing and procedures. Safety in the critical care environment is also discussed.

- Module 9 gives an introduction to the non-clinical aspects of intensive care medicine, such as research and audit, human factors and the law.

- Module 10 is a self-assessment module, providing relevant multiple choice questions that will be useful for anyone preparing for an exam or wanting to test their knowledge.

Whilst the programme was produced with trainees undertaking Stage 1 training in ICM in mind, we would challenge anyone not to find something to learn within e-ICM.

Finally, it goes without saying that the production of e-ICM has been a team effort. The project was made much easier by being able to learn from the experiences of e-LA and we are grateful to Ed Hammond for providing that expertise. We have also been fortunate to work closely with Ali Hall, the editor for the e-LA ICM module, and Jamie Strachan (RCoA Technology Fellow) was invaluable in helping with peer review. We currently have a number of authors and editors who are still busy producing more content, and our thanks additionally go to them. Faculty support has been provided by Jyoti Chand and Daniel Waeland. The project lead is Nick Cleary and the lead instructional designer Lynne Perry.
EPM Lite is based on RAT (Recognise, Assess, Treat), a stepwise system for pain management. The course has short lectures followed by case-based discussions, and the FPM has taken on the project of introducing EPM Lite into medical schools.

The course is now established, or is in preparation, at 14 of the 34 UK medical schools. The course can run in a variety of guises: an hour-long version held at weekly medical student seminars; a version for small-group teaching in Years 2 and 3; another for use in Year 4 during the students’ Anaesthesia Specialty Study Modules; and another for use on a Final Year ‘survival’ course in preparation for taking up FYI posts.

Feedback has been positive. Students value the RAT approach, the WHO ladder for cancer pain, and the ‘reverse ladder’ for postoperative pain. They also like learning about the difference between neuropathic and nociceptive pain, and that different drugs are used in different types of pain.

We recently piloted a version with core anaesthetic trainees. Feedback was excellent, and trainees’ evaluation of what we could do to improve the course has given us a start on how we can develop meaningful scenarios for trainee anaesthetists.

More broadly still, there are plans in some hospitals to introduce the RAT model as a system for teaching pain management across a whole trust.

For me, this ‘whole-trust’ initiative is the way forward. We need to appreciate the RAT approach as a simple systematised model for all healthcare workers. What would it be like if at a cardiac arrest only you and the medical student had heard of the ‘ABC’ approach? This will be a particular area of interest for Helen Makins (Gloucester), who has recently become the EPM Lite Deputy Lead.

If you think you could use EPM Lite with any group of staff, we would love to hear from you. Email fpm@rcoa.ac.uk
In 2017 the Royal College of Anaesthetists will celebrate 25 years since gaining its Royal Charter. There will be a programme of events and activities throughout the year that will celebrate our achievements.

Get Involved
We are developing a series of regional public and patient engagement events to promote the work of anaesthetists and increase the understanding of anaesthesia among the general public.

Competitions
We will be running competitions during 2017 for medical students, foundation year doctors, trainees, budding photographers, and recognising local trainers contributions.

Visit www.rcoa.ac.uk/rcoa25 to find out more.

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RCoA events for anaesthetists and the public

6 FEBRUARY 2017
The history of local anaesthesia by Dr William Harrop-Griffiths at The Museum of London

8–9 MARCH 2017
RCoA Anniversary Meeting: Landmarks in UK Anaesthesia, London

17 MARCH 2017
RCoA Career Day, London

21 MARCH 2017
Xtreme Everest: taking medicine from mountainside to bedside by Professor Mike Grocott at The Museum of London

Supported events
The RCoA will be supporting various events throughout 2017

> Oxford
> Newcastle upon Tyne
> Warrington
> London
> Cardiff
> Inverness
> Edinburgh
> County Durham
> Suffolk
> Nottingham
That was my wife’s initial (and understandable) reaction when I declared that I was putting my hat in the ring for the role of Deputy Director, Health Services Research Centre of the National Institute of Academic Anaesthesia.

Having settled into the role over the last few months, I thought it would be good to share with College members and fellows what the job is about – after all, it is the College that provides all the structural funding for the Health Services Research Centre (HSRC).

Undeterred, following open advert and interview, in May 2016 I was appointed to a job with one of the longest job titles in anaesthesia.

Most UK anaesthetists have some awareness of the role of the National Institute of Academic Anaesthesia. Based on a non-scientific random sample of colleagues and people I’ve met at conferences, rather fewer know about the HSRC. So, here’s a very brief overview.
The three principle aims of the HSRC are:

- initiating and coordinating large scale clinical audits and quality improvement initiatives
- methodological innovation in clinical measurement
- conducting and facilitating research to improve patient outcomes.

Underpinning these are five strategic foci:

- defining quality
- evaluating quality
- improving quality
- developing people
- communicating and engaging.

Let’s face it, that sounds a bit dry! So, what does it all mean in practice? How does it impact on members, fellows and, most importantly, our patients?

Big ticket items include the National Audit Projects, the National Emergency Laparotomy Audit, the Sprint National Anaesthesia Projects, and the Anaesthesia Sprint Audit of Practice. These are linked by a few common themes: they are all HSRC projects, they are all collaborative between professional organisations, and they all have a big impact on our profession and our patients.

In addition, they are/were all led by people outside London. There is a misperception that HSRC activity is focused on some London-based elite. For the record I have never worked in London, and Nottingham is variously viewed as being in the Midlands, in the North, or not-in-London, depending on the frame of reference.

Over the coming months, we are going to be fleshing out some of the other work that the HSRC does. I’m not going to steal their thunder, other than to highlight the very deliberate interplay between research and real-world improvements in patient care.

Inevitably, as Deputy Director, I have my own portfolio of activities within HSRC. I won’t go into all of them here, but will just give a flavour.

‘Big data’ is an increasingly important part of health services research. With the greater coverage and quality of national audits, research, and administrative databases in both primary and secondary care, there is a fantastic opportunity to understand better how the interaction between patient, process and place of care impacts on outcomes that matter to our patients. Several groups around the UK are already undertaking work in this area, and I am leading a stream of work at HSRC looking at how to facilitate advances in this area. If members or fellows have an area that they think would be worth looking at, please do let me know. Embedded in this work is the importance of trust. When we start looking at data that patients, staff or organisations have provided in good faith, it is vital that we repay that trust with care in the way the data are handled.

The HSRC has a variety of fellows doing some fantastic work. Currently the funding arrangements mean that their clinical work is in London. We need to widen and improve the sustainability of funding arrangements for these fellows. No one is pretending that there is any spare cash in NHS budgets, but I’m hoping to work with training programme directors and clinical directors to look into how HSRC fellows that aren’t tied to London can work with the HSRC.

The success of my work, and of HSRC as a whole, depends on relationships, so for the vast majority of people who have never met me, here’s an incomplete précis of the person behind the awful photo. I’m married to Sarah, a divisional nurse in Nottingham, and we live with our two daughters within shouting distance of Trent Bridge cricket ground.

In my day job I’m a hip-fracture and perioperative patient safety researcher, and I do clinical sessions mainly in neuro and orthopaedic trauma. Outside of work, you’ll find me running, helping to run our church Sunday School and learning to play jazz bass guitar.

I’d love to hear from members or fellows who have ideas or comments on the work of HSRC: iain.moppett@nottingham.ac.uk
Over the past year, the phenomenon of ‘cultural appropriation’ – the adoption or use of elements of one culture by members of another culture – has aroused considerable media debate.

The row began in March 2016, when students at Bowdoin College in Maine, USA, held a ‘tequila-themed’ party to which a number of revellers wore sombreros. The university immediately began an ‘investigation’ into a ‘possible act of ethnic stereotyping’, offered counselling to help students deal with the emotional impact of the sombrero-wearing, and created ‘safe spaces’ where, presumably, sombreros [and any other potentially upsetting headgear] were firmly off-limits.

The debate was reignited in September by the author Lionel Shriver at the Brisbane literary festival. Perhaps anticipating trouble, the festival’s organisers tweaked the original title of her talk – ‘Fiction and Identity Politics’ – to the more neutral ‘Community and Belonging’. However, Shriver stuck to her original subject matter, describing cultural appropriation as a ‘passing fad’, and arguing that ‘unless [fiction writers] write from the perspective of people different from themselves, there is no fiction… only memoir’. She used the Bowdoin college furor to illustrate her point, before concluding: ‘The moral of the sombrero scandals is clear: you’re not supposed to try on other people’s hats. Yet that’s what [authors] are paid to do, isn’t it? Step into other people’s shoes, and try on their hats.’

Even Shriver was surprised by the reaction. One woman walked out – and subsequently wrote an article for the
Guardian describing her disgust at her remarks; another shouted ‘How dare you come to my country and offend our minorities?’ Meanwhile the festival’s organisers immediately disavowed her comments, removed her talk from their website, and hastily arranged a counter-conference to rebut her views.

Cultural appropriation in perioperative research
Whatever you think about cultural appropriation, the notion that you can’t legitimately understand another person’s perspective unless you have ‘lived experience’ of it has some uncomfortable ramifications for anaesthesia and perioperative medicine. Leaving aside the basic fact that many anaesthetists have never had an anaesthetic themselves, most of us also have no experience of the diseases we encounter every day, though they may be life-changing for patients. How can we understand the full emotional, psychological and physical impact of having, say, breast cancer, if we’ve never experienced it ourselves?

And if we can’t understand it properly, what makes researchers think they know which outcomes are most important? Trials testing interventions which aim to improve patient care make the implicit assumption that we ‘know what’s best’ for patients. No one tells a surgeon he can’t do a trial involving colorectal cancer patients just because he’s never had it himself. Are we not guilty of gross cultural appropriation when we assume we know which outcomes matter most to patients, and which trials to conduct to improve their lives?

The obvious answer is that, while an author might require a deep understanding of what life is like for a particular minority group to write convincing (and legitimate) fiction about their experiences, clinicians do not need to appreciate every aspect of their patients’ lived experiences to discuss with them a particular course of treatment. Indeed, shared decision making explicitly acknowledges that clinicians can’t appreciate all aspects of their patients’ lives – hence the need for us to say ‘I can advise you about the medical risks and benefits of a particular treatment, but I can’t decide which is best in the context of your particular life circumstances’.1

But what does matter to patients?
Surprisingly few studies have explored the fundamental question of ‘what matters’ to patients. There is good evidence of ‘preference misdiagnosis’: clinicians are pretty good at diagnosing disease accurately, but not so good at ‘diagnosing’ what patients want done about it.2 There is also evidence that the research questions which clinicians and researchers consider ‘important’ often differ from those that patients want answered.3

As part of the Health Service Research Centre’s COMPAC project (Core Outcome Measures for Perioperative and Anaesthetic Care)4, we are conducting surveys and in-depth interviews of patients to get to the bottom of what matters most to patients having major surgery. For this study, entitled P-COMMaS [Patient-Centred Outcome Measures for Major Surgery], we’re also surveying and interviewing clinicians about what they perceive to be truly important perioperative outcomes. Because – ultimately – we’re with Lionel Shriver on this one. Clinicians do have something legitimate to say about their patients’ experiences of major surgery, even if they’ve never experienced it themselves.

[Just don’t wear a sombrero while saying it.]

References
3 Crowe S et al. Patients’, clinicians’ and the research communities’ priorities for treatment research: there is an important mismatch. Research Involvement and Engagement 2015;1:2 [published online first: June 2015].
PATIENT PERSPECTIVE

ONE-TO-ONE

Communications between clinicians and patients remain a constant topic at the Lay Committee.

The last meeting was no exception, although I hope we have moved from the anecdotal to more of an evidence-based approach. This brief review focuses on papers concerning communications in anaesthesia care.

One of our members, Christine Barrowclough, recently examined the literature concerning communication skills. While most of the peer-reviewed studies were conducted outside the UK, and some are of variable quality (sample size, measurement of outcomes), her key conclusions were as follows:

- there is consistent and extensive evidence that the anaesthetist’s communication skills (CS) are key to patient satisfaction
- CS should include responsiveness to patient concerns and emotional support. Such CS can help to reduce patient anxiety
- patients value being involved in decision making in anaesthetic care
- positive suggestions and images at pre-induction and re-emergence may reduce pain perception and anxiety
- there are some indications that anaesthetists develop idiosyncratic and repetitive ways of communicating, not always drawing on the evidence base of how best to communicate with patients
it is important to get feedback from patients on the quality of CS

more formal teaching of CS, especially on how to deal with more challenging situations, may be required

there are some indications that training programmes specific to CS in anaesthesia care may improve patient satisfaction and decrease anxiety.

There have been numerous studies of patient satisfaction in anaesthesia (Nuebling et al, 2013). An early review of studies of perioperative anaesthesia care by Heidegger et al (2006) showed that, although ‘medical factors’ such as pain and ‘complications of anaesthesia’ were important to patient satisfaction, since high safety and treatment standards reduce the likelihood that such factors will impact on patients, it is the areas of information, communication and the personal approach (aspects of relationships involving concepts of ‘kindness/regard’ and emotional support and sensitivity) that are the most important factors predicting satisfaction. A further review (Heidegger et al, 2013) of eight studies from 1996-2011 confirmed the earlier findings.

A recent Australian study (Hocking et al, 2013), with a substantial cohort of more than 700 patients, found similar results. Communication with the anaesthetist was the key factor in patient satisfaction, and the skills that were most valued included gentleness and attention, information and confidence, and addressing the patient’s concerns.

Shared decision making is one aspect of CS; a recent Swiss study which assessed patient preferences for involvement in decision making regarding their anaesthetic care (for example, regional versus general) indicated most patients want to be involved in decision making (Flierler et al, 2013).

Unintended consequences

My local Clinical Commissioning Group (CCG) recently announced that elective surgery will be delayed for patients who smoke or have a body mass index greater than 30. Instead, patients will be diverted to undertake six months of health-promoting activities, including smoking-cessation and weight-management programmes. For the most part this seems to be driven by both an effort to improve the health of the local population and the need to save money. The CCG is facing a reported £8 million deficit in this financial year.

The biggest surprise is the limited opposition to the move – just a few murmurings from a surgeon. Only a few months ago, a neighbouring CCG was instructed to stop such a proposal, on the grounds that they were not actually offering smoking-cessation/weight-management advice and support. Just down the road, patient and community groups have taken to the streets in large numbers, drawing substantial media attention, to oppose the transfer of services from hospital buildings in need of significant investment.

As I walk round town, I notice there are a significant number of people who are smoking and/or may struggle to meet the BMI threshold. How will they react then? Will they take to the streets and demand the clinical evidence? Will the patients be able to keep to the diet, carry out the exercise and/or give up the cigarettes? Will the CCG actually make savings or does this policy just delay the spending by six months? Who will make sure the approach does not unfairly impact any section of the population (e.g. low income groups)? When will we all become less obsessed with tired hospital buildings and turn our attention to health and wellbeing?

I don’t have any answers and I’m not opposed to change. I do know that the policy will only be successful if it is well implemented. That means, in part, making sure that communication between individual clinicians and individual patients is very good.
Society moves on, the world changes almost imperceptibly, and our lives take on new challenges each day. The life of a junior doctor is arguably amongst the most challenging of experiences as they come to terms with their knowledge and responsibilities while living in an ever-changing world. Today’s younger generation have grown up in a technologically aware world, where using computerised devices is as natural as climbing trees was to their parents and grandparents. Doctors have to answer complex questions on a daily basis, raising challenges to their very essence as well as to their practical experience. Medical knowledge seems to grow exponentially, creating a demand for each individual to know more and understand more; medical schools teach students to self-reflect regularly on

THE NHS CULTURE OF CARE

IF WE CARE FOR OUR PEOPLE, OUR PEOPLE WILL CARE FOR US

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learning – a process that has become almost automated, and trainees appear more self-aware and perhaps more self-conscious than their senior colleagues.

**Daily challenges**

Doctors are regularly exposed to assaults on their professionalism and attitudes, and on the ethos of the NHS. Experienced doctors find that they often view their daily job as a process to be completed rather than as a vocation to be pursued. A series of reports and editorials highlight the difficulties being experienced by doctors, and indicate issues for everyone working in healthcare and indeed in the public sector today. It is widely recognised that poorly functioning, disenfranchised teams result in poor quality care and worryingly high instances of mental health issues in medical professionals, and yet the current system denies them the team structure afforded by the traditional firm structure.

The loss of the Doctor’s Mess and the medical dining room, while accepted as necessary in an egalitarian world, has led to isolation of senior and junior doctors alike. The creation of a flat hierarchy leaves Foundation doctors as strangers to their consultants, with no obvious individual point of reference to guide them through the early days of their apprenticeship. We have lost the supervisory role of the SHO to HO, Registrar to SHO, where each person knew their immediate senior well, and where they became friends in their adversity.

**Shortfalls in care**

Carers care, singers sing and dancers dance – but who cares for the carers? Social care and healthcare in the UK employ maybe 2 million people. Each and every day people turn up to work with an expectation of performing a good job, and of going home with the satisfaction of knowing they’ve helped others in need. Sadly, a series of reports have highlighted shortfalls in care delivery, and even a fairly superficial look reveals that the root of many problems is stress in the workplace and a lack of support for workers. Doctors and nurses are no more likely to be resilient in the face of these challenges than any other member of society, but they also suffer from the often-inflated expectations of the public and employers. There is a recognised need for pastoral support for all staff groups, and doctors may need a special kind of support. So who does care for those providing care if we ourselves don’t?

High levels of staff engagement are a measure of top performing organisations; in industry this means higher output and efficiency, resulting in larger profit margins. This has been mirrored in healthcare with improved outcomes, lower mortality and increased levels of patient and staff satisfaction when individuals feel part of a strong team and are ‘bought into’ organisational aims. Sadly, staff surveys in the NHS regularly reveal less than 70% satisfaction, whereas in highly successful commercial businesses a figure below 97% would be cause for concern. Yet this is a healthcare service and we are missing something in the care of our own staff. High-level satisfaction, engagement and re-energised teams would benefit the NHS through improved patient outcomes and better reputation, not to mention significant financial benefits.

While organisations work to address these problems, and helplines and pastoral support are available to varying degrees, each time someone needs help there is a barrier to overcome: the first challenge is to recognise that there is a problem and the next is to speak to someone. It may be that this is a stage too far for some, and that prevention is a better strategy. Medicine has always assumed that prevention is better than cure, so how do we develop prevention strategies for our own mental health problems?

**Solutions? Maybe...**

How do we start to raise the bar? Where do we start if the system is so broken that staff are leaving or suffering ill health trying to attain perfection? Many commentators have posed this question, and suggested answers include being given the opportunity to meet, share and build a common goal, and being given more freedom to express their wishes and desires without fear of criticism or retribution. Doctors need opportunities to learn, reflect and mutually support each other.

In the next issue of the Bulletin, read part two of this article in which we will describe a successful series of workshops we run in Wessex that address the issues raised.
In September 2015 the Bulletin ran a series of themed articles on the College’s Perioperative Medicine programme, highlighting how we might share good practice to support clinicians who want to, or are already, providing local perioperative medicine solutions.

We also looked at how the future training of anaesthetists can support the delivery of perioperative medicine. Fifteen months on, how is that work being shaped both within and beyond the College and in response to the external and unprecedented challenges that face our national healthcare system at this time?

**State of care**
The Care Quality Commission launched their ‘State of Care’ report in October, and one of the key messages was that hospitals that achieved good or outstanding ratings effectively planned and co-ordinated care and treatment with other services, addressed issues from the patient’s point of view, and had a strong drive to improve services for patients. Perioperative medicine is well placed to link many aspects of the patient’s hospital journey and encourage greater links with primary and social care. Some of our work over the last 12 months has been to highlight to policy makers and commissioners where perioperative medicine can make a difference.

**Sharon Drake**
Deputy Chief Executive and Director of Clinical Quality and Research
Choosing wisely
We recently contributed to the Academy of Medical Royal Colleges (AoMRC) ‘Choosing Wisely’ campaign, a global initiative, which works with both patients and clinicians, and aims to reduce – on the basis of the evidence – unnecessary tests, treatments and procedures.

Our approach has been to highlight where the specialty already ensures efficient and effective use of hospital resources, including:

- considering day surgery as the default for most elective surgical procedures
- reducing admission to hospital the day before an operation through improved preoperative assessment and preparation prior to elective surgery.

‘Choosing Wisely’ focuses on a shared decision-making consultation to discuss a patient’s individual chance of benefit or harm from surgery, and to identify the patient’s personal preference. Perioperative medicine encourages greater input from anaesthesia into planning the patient’s journey, so that all risks, not just the surgical ones, are taken into consideration.

With the recent introduction of new units of training in perioperative medicine at core, intermediate, higher and advanced levels, there will be more opportunities for trainees to have greater exposure to patients at pre-assessment clinics. This will help build clinical experience and confidence in talking to patients about their preferences, and in discussing risks or marginal gains involved with some procedures. Across our specialty, this increased interaction with patients will have the positive effect of enabling shared decision making and understanding what patients really want and value.

National agendas
We continue to promote perioperative medicine as offering solutions to many of the challenges facing healthcare through our responses to external consultations. We have highlighted the benefits of perioperative medicine in our response to the House of Lords Select Committee Inquiry into the Long Term Sustainability of the NHS, and in our response to the AoMRC’s initiative on delivering sustainable health and care systems.

The 2014-15 Report of the Chief Medical Officer for Scotland, ‘Realistic Medicine’, is complementary to the RCoA’s Perioperative Medicine programme, with a focus on building a personalised approach to care, shared decision making, reducing harm and waste, reducing unnecessary variation in practice and outcomes through evidence-based approaches, managing risk, and becoming improvers and innovators. Similarly, NHS Wales is promoting the principles of ‘prudent healthcare’, with an emphasis on healthcare that fits the needs and circumstances of patients, and actively avoids wasteful care that is not to patients’ benefit.

Local engagement
The principles and ethos of the Perioperative Medicine programme have always been part of the anaesthetist’s way of working. Implementation of the programme is not intended to be top-down or didactic, and its success will be dependent on local engagement, supported by effective communication between the College and perioperative medicine teams.

At the time of writing we have 121 perioperative medicine local clinical leads, providing an important link to your hospital’s work. We will support this network in promoting and delivering perioperative medicine solutions that work locally, and on 31 January 2017 we are hosting a meeting for all our leads where we will showcase local case-studies and provide an opportunity for peer-to-peer engagement.

We recently set up a Perioperative Medicine Innovation of Practice Group made up of clinicians with expertise in their respective areas of perioperative medicine. The role of the group is to assist in the development of ‘toolkits’ – providing resources to enable hospitals to implement and develop perioperative practice within their sites, along with providing guidance and support to the perioperative medicine local leads. The group will continue to expand and develop to encompass a broad range of members with experience across the spectrum of perioperative care.

Following the RCoA membership survey, we are planning a more extensive survey of anaesthetists’ views on perioperative medicine. In the meantime, please do share your views on how this work is developing. You can contact us at perioperativemedicine@rcoa.ac.uk.

SHARE YOUR VIEWS ON HOW THIS WORK IS DEVELOPING BY CONTACTING PERIOPERATIVEMEDICINE@RCOA.AC.UK
UNDERGRADUATE TRAINING IN ANAESTHESIA

A personal viewpoint

Dr Ramana Alladi
RCoA Education Programme Advisor

Medical students are generally impressionable and tend to form opinions regarding their career opportunities during their undergraduate years.

I believe that this is the best time to inspire them and introduce them to the breadth of career opportunities anaesthesia can offer. There is evidence that the perceptions of students may be changed significantly by exposure to the specialty. This emphasises the importance of exposing undergraduates to the wide scope of rewarding careers in all specialties and ensuring a high quality experience.1

Furthermore, Mackie and colleagues stated that ‘Foundation Year 1 trainees on a one-month anaesthetics training programme gain confidence in a wide range of areas that form the basis of medicine. These include preoperative assessment and optimisation, acute pain management, recognition of the sick patient, resuscitation, intravenous access skills, airway skills and fluid management, and, vitally, knowing when and whom to call for help.2
Not only is anaesthesia the largest in-hospital specialty, but anaesthetists also influence and work with most other specialties, often leading the way in many areas of care and safety. It is high time that our specialty was recognised as important enough to be taught separately as a mainstream subject on a par with both medicine and surgery. I believe that the profession is missing an opportunity. Teaching of anaesthesia should be represented proportionately in both the undergraduate and Foundation years’ curricula. The aim of this article is to highlight possible ways the College can facilitate the required change.

Despite recognition of the need to standardise these placements,\(^1\) at present there is no specific guidance from the College on the anaesthetic curriculum at undergraduate level. There is a wide variation between universities in terms of both inclusion of subject matter and quality of teaching, and they are currently solely responsible for their individual curricula. I believe that it is in the interests of the College to take a lead and produce guidance on how anaesthesia is taught to undergraduates. This will raise the profile of the College and anaesthesia as a specialty, and will help to produce doctors who are better trained in many areas of modern medicine. An undergraduate curriculum document could be generated from elements of the existing core curriculum. Recently, the College has been actively involved in developing perioperative medicine. At the undergraduate level this should be taught as a part of an anaesthetics placement. This should be part of the ongoing modernisation of medical education.

**Strategy**
The following is a broad outline showing how the College can facilitate this process:

- form a subcommittee overseen by the Training Committee
- liaise with undergraduate trainers in all medical schools in the UK
- work with the GMC
- discuss at College Tutors’ meetings and Regional Advisors’ meetings
- highlight areas in the present core curriculum relevant to undergraduates
- support the development of assessment systems for undergraduates
- supplement existing teaching programmes by using High-Fidelity Simulation, with role playing in taking history/communication, etc.
- send formal guidance documents to universities on anaesthesia curricula.

There are ample opportunities in many situations and environments for the delivery of high-quality individual or group teaching. A typical week of teaching could comprise the following half-day sessions:

- trauma theatre
- emergency theatre
- acute-pain round
- pain clinic
- critical care/HDU
- general theatre
- obstetric unit
- remote site and transfer (MRI/ECT)
- skills/simulation.

I believe it is possible to achieve this with existing human resources. Senior doctors, including SAS doctors and senior trainees, could be involved and, if needed, developed as educators in a mutually beneficial process. This would create an educational framework involving all necessary stakeholders, and would ensure engagement, recognition and protected time for training.

It is time that anaesthesia was introduced at undergraduate level as a mainstream subject, and national guidance should be given by the College on the curriculum and its administration. The need to address this important issue will give our College an opportunity to lead the way in shaping and standardising the new undergraduate educational experience.

**Acknowledgement:** I would like to thank Dr Sri Logarajah for his assistance in preparing this article.

**References**

DEVELOPING UNDERGRADUATE EDUCATION IN ANAESTHESIA

Undergraduate medicine is currently going through the largest-ever universal overhaul and the College is engaging with medical schools and the GMC to see how best to integrate anaesthesia, perioperative medicine, pain medicine and critical care.

Dr Jonathan Sadler
Education Fellow, RCoA

Dr Chris Carey
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Dr Alladi’s personal viewpoint on undergraduate education in anaesthesia, published in this edition of the Bulletin, will no doubt resonate with many.

Despite anaesthesia being the largest in-hospital specialty and interacting with patients in a huge variety of settings, medical students spend comparatively little time in anaesthesia and intensive care medicine.

Regarding anaesthesia as a ‘postgraduate’ specialty denies students excellent opportunities to learn a wide range of skills and knowledge that would benefit them greatly, regardless of their ultimate career choice. Whilst applications to anaesthetics training are at a relatively high level, there is evidence to suggest that both early experiences at medical school and even medical schools themselves can influence eventual career choice, making it even more important for anaesthesia to be included in undergraduate curricula.

There have been many recent advances in undergraduate medical education, and the most important of these is the ongoing development of the GMC’s new Medical Licensing Assessment (MLA). This will form the basis of a standardised assessment system for anyone wishing to practice medicine in the UK. Undergraduate exams are currently set by individual universities, and there has always been considerable variation in both the format and content of the exams which lead to the award of the medical degree. The MLA will form part of the final medical exam, with universities also able to set additional
bespoke assessments. Many of the details of how the MLA will work in practice are yet to be finalised, but it will undoubtedly have considerable implications for undergraduate education and training.

The Royal College of Anaesthetists has historically had limited links with undergraduate education, in contrast to many other Medical Royal Colleges. This is now set to change, and the College’s 2016-2021 Strategic Plan includes an objective ‘to work with medical schools to ensure that anaesthesia and perioperative medicine are integrated into undergraduate programmes’. The aim of establishing links with undergraduate educators initially arose from the Perioperative Medicine Programme, introduced in 2015. However, it was clear that a programme encompassing the whole of anaesthesia, perioperative medicine, pain and critical care medicine would afford the most benefit.

A plan has been established to support this work. Firstly, a survey has been conducted by Rob Stephens and Claire Frith, reviewing the current provision of training across UK medical schools. Secondly, a national network of undergraduate trainers is being established.

An undergraduate trainers’ engagement event was held at the College on 13 October, and was attended by around 50 trainers representing almost all medical schools. This event featured a discussion in which trainers stated what worked well in their schools, and what they thought the College should do to improve education.

The third aspect of this initial plan is to develop a framework outlining areas of training which should be covered as part of every undergraduate course, based on feedback from the engagement event. Other colleges, such as the Royal College of Surgeons and the Royal College of Psychiatrists, have already introduced their own curricula for undergraduates, setting out specific areas that should be covered explicitly and, in the case of the surgical curriculum, in meticulous detail. However, it was felt that this approach would not be favoured by trainers, especially given the heterogeneous nature of current educational programmes.

It is intended that the undergraduate training framework will ultimately allow considerable flexibility in its implementation, and will support diversity between institutions. This includes the provision for a multidisciplinary approach to training where favoured. It would also make sense for such a document to form the basis of the elements of the MLA. Through this initiative, the College is aiming to raise the profile of undergraduate training and provide support for undergraduate training leads in their work. The fundamental importance of undergraduate medical education is well recognised, and the College’s developing role in this area represents a significant new facet to its work.

References
LEADERSHIP AND MANAGEMENT AS A CORE PROFESSIONAL ACTIVITY

Good leadership and management are central to our role as clinicians and can result in improved quality and safety of care.

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Dr Nathalie Stevenson
Locum Consultant in Anaesthetics and Intensive Care, Barnet Hospital

The NHS faces unprecedented financial and operational challenges as a result of rising demand for services, constrained resources and a requirement to deliver £22 billion of productivity improvements by 2020-21.

In the last King’s Fund Quarterly Monitoring Report, 67% of providers ended 2015/16 in deficit, while 65% of trust finance directors felt patient care in their local area had worsened in the past year. John Appleby, Chief Economist at the King’s Fund, made reference to the fact that ‘eradicating the deficit and improving performance is going to be a Herculean challenge.’ It is clear that the NHS is in need of strong leadership and innovative vision to steer it out of this crisis. In 2012, a leadership review undertaken by the King’s Fund concluded that the business case for leadership and engagement was compelling.

Case studies and research have demonstrated that effective clinical leadership lifts the performance of healthcare organisations. Consider the case of Kaiser Permanente Colorado, a US health insurer and provider. In the 1990s it was struggling with declining indicators of clinical and financial performance. Jack Cochran, a paediatric plastic surgeon, became executive medical director and redefined the role of the clinician to ‘healer, leader and partner.’ Clinical leadership became a fundamental driver for improving outcomes. In just five years, patients were more satisfied, staff turnover fell...
and net income increased from zero to US$87 million. It went on to become a beacon of quality in US healthcare.4

In this case, what changed for clinicians was their professional identity and sense of accountability. Clinicians recognised the need to broaden their focus and learned to collaborate with clinicians and non-clinicians alike in decisions. It was noted that the responsibility they felt for the patient extended to the organisation itself.

So our clinical involvement in leadership matters, and it is not just for the chosen few but for all of us from the ‘ward to the Board’.5 Healthcare systems are too complex for heroic leadership or for a command and control culture. All of us lead, perhaps at times without conscious awareness, and many of us lead without authority.

Leadership has been conceptualised as a triad made up of the leader’s position within the organisation, the personal qualities of the leader and the social process associated with leadership (see Table 1).6

Anaesthetists are well placed within the structure of healthcare delivery to lead and identify the need for change. Our work takes us to various different environments where we interact with multidisciplinary teams. It is because of this that we can develop insights into how care is delivered in each part of the hospital, and how well the different environments and teams connect up and integrate to collaborate and aspire towards the strategic aims of the organisation. Anaesthetists should feel less threatened by the prospect of change as they have no so-called ‘turf’ to lose, and can thus be the drivers for change.

It is therefore our view that it is not enough to consider leadership as an extra-curricular activity; rather, it should form part of our core professional work, as set out in the General Medical Council’s document Tomorrow’s Doctors.7

Conclusions

Leadership is for all and can result in increased quality and safety for patients. It should be embedded as part of our core professional activity and this should start in medical school. The mark of great leadership is felt at every level and by every patient. Through becoming more involved in leadership and management initiatives, doctors should not only become more effective but also happier in their roles with a renewed sense of loyalty and ownership in the NHS. This would benefit our profession and, more importantly, the patients we serve.

In the next issue of the Bulletin, we will discuss the opportunities for leadership and management development which are available to anaesthetists.

References


Table 1 Conceptual perspectives on leadership. Adapted from Hartley and Benington.6

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<th>Definition</th>
<th>Features</th>
</tr>
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<tbody>
<tr>
<td>Organisational position</td>
<td>Defined in terms of formal organisation authority, position, leadership roles and/or professional status</td>
<td>Status and/or profession Personal and organisational authority Often associated with senior or supervisory roles Linked to organisational effectiveness</td>
</tr>
<tr>
<td>Personal qualities of the leader</td>
<td>Defined in terms of behaviours and personality of individual leaders</td>
<td>Individual attitudes and behaviours Personality traits Learned capabilities and skills Concerned with standards of personal effectiveness</td>
</tr>
<tr>
<td>Leadership as social process</td>
<td>Defined in terms of social interaction with followers with an emphasis on social influence attempts, communications, empathy for others, empowerment and coaching of others</td>
<td>Relational Influencing/motivational skills Effect on followers</td>
</tr>
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XTREME EVEREST: THE STORY SO FAR

Kay Mitchell
Senior Research Manager,
University Hospital Southampton NHS Foundation Trust Director,
Xtreme Everest Oxygen Research Consortium

THE XTREME EVEREST OXYGEN RESEARCH CONSORTIUM HAS GROWN OUT OF A RESEARCH PROJECT CONCEIVED BY MEMBERS OF CASE MEDICINE (UCL CENTRE FOR ALTITUDE, SPACE AND EXTREME ENVIRONMENT MEDICINE) WWW.CASE-MEDICINE.CO.UK
Xtreme Everest was developed to carry out research into improving outcomes for critically ill patients. Low oxygen levels are a critical factor for these patients, whether in intensive care, accident and emergency, or undergoing major surgery. Similarly low oxygen levels are experienced by individuals visiting extreme environments such as those found at altitude. However, research results from healthy volunteers at altitude are not as problematic as those from critically ill patients in terms of confounding. This is because the underlying issues that cause someone to become critically ill are not present in healthy volunteers. Although it has been possible to simulate low-oxygen environments in chambers, the studies are expensive to run, and can only accommodate small numbers at a time. Therefore, Xtreme Everest has used exposure to environmental hypoxia as a model for the majority of its critical care research to date.

The work has been funded from a number of sources, including individuals, companies, charities, and public institutions – including the Royal College of Anaesthetists. It has resulted in over 30 journal publications, with additional related articles, and countless ‘opportunities to view’ via television, radio, print and electronic media, as well as growing exposure via social media.

Background
The first meeting of Xtreme Everest took place in March 2004. Xtreme Everest includes investigators from a variety of health-related disciplines, commercial sponsors, third-sector grant-giving bodies, and governmental organisations, as well as individuals, members of the media, and healthy volunteer subjects.

The research portfolio has included eight high-altitude research expeditions investigating environmental hypoxia, involving highland and lowland adults, and lowland children; and two research studies carried out in chambers. Caudwell Xtreme Everest, our largest expedition to date in 2007, involved 222 lowland subjects who were studied up to Everest Base Camp (5300m), and 14 of the investigators who were studied up to the South Col at 8,400m. Baseline studies were carried out at sea-level (75m) on all subjects, and then repeated in dedicated field laboratories in Kathmandu (1,300m), Namche Bazaar (3,500m), Pheriche (4,250m), and EBC (5,300m). Members of the subgroup underwent additional testing at the Western Cwm (6,400m), the South Col (7,950m), and the Balcony (8,400m). Repeated measurements included core physiological data, maximum exercise capacity, metabolic efficiency, neurocognitive
Themes investigated over the various expeditions have been identical, some have changed to exploit new opportunities, for example, epigenetics.

**What we found**

Perhaps the most notable results so far have been the arterial blood-gas data obtained from our climbing investigators close to the summit of Everest. The lowest PaO₂ recorded was 2.55 kPa. This was from one of four subjects who had just reached the summit of Everest. The subjects took the samples from each others’ femoral arteries (average PaO₂ was 3.28 kPa), and each sample was obtained at the first attempt, demonstrating that the investigators’ fine-motor skills were still present despite profound hypoxaemia. These results have driven the team to pursue the concept of permissive hypoxaemia, resulting in the publication of a Cochrane Review on the topic, and the development of clinical feasibility studies.

Highlights from the neuroscience group have included a better understanding of cerebral blood flow, cerebral venous congestion, and its contribution to raised intracranial pressure and high-altitude headache in the presence of extreme hypoxaemia. Investigators interested in oxygen delivery have presented data related to changes in microcirculatory blood flow and muscle oxygenation in the presence of hypoxaemia, and the role of nitrogen oxide. Studies investigating oxygen utilisation have highlighted changes in muscle energetics, skeletal mitochondria, cardiac function and energy metabolism.

Work is ongoing to publish additional data related to these and other topics, including exercise capacity, metabolomics, genetics, and epigenetics.

**Publications related to all our research work can be found at:**

**WWW.XTREME-EVEREST.CO.UK**

**References**

Seventy-five members made the journey to York on 3 November 2016, but sadly there was one notable absentee – our invited speaker, Mr Howard Driver. Poor Howard was struck down with what may have been a norovirus infection the night before. He has had 50 years with the Fell Rescue Association and has rarely missed a ‘shout’, so it was particularly unlucky that he was unable to pass on his accumulated wisdom. Fortunately, Chris Johnson was willing and able to fill in with a wonderful talk on Wilderness Medicine (the second edition of ‘The Oxford Handbook’, of which he is an editor, has just come out). We learnt a lot of very interesting things – did you know that 99% of murdered Britons meet their fate abroad, and that our chances of being smashed up are also much, much higher on foreign roads? For real ‘red-meat’ risk, we could have a go at Bat Suit Flying, which has a mortality of 1 per 60 ‘flights’, but I forgot to ask whether it is any safer in the UK.

Professor Ravi Majahan told us something of what is happening at Churchill House. It seems that the College has concluded that it has to take on a lobbying role, to try and make sure that the Government gets the best and most accurate information possible.

Steam engines are like big friendly kettles with wheels and whistles. The collection at the York museum ranges from delightful little shunters to the beautiful Mallard, and an absolute behemoth built for the Chinese. It was a grand day out, and we are very grateful to Karen Slater and Michelle Crosley for organising it.

The National Railway Museum, York

The next meeting will be on the 6 June 2017 at the College.
The invited speaker is Harriet Tuckey
Dr Reza Noori  
ACCS Anaesthetics Trainee (CT3)  
West of Scotland Deanery, Forth Valley Royal Hospital

Dr Laura Irwin  
Core Anaesthetics Trainee (CT1)  
West of Scotland Deanery, University Hospital Crosshouse
CYCLING THE ANDES

Lifebox fundraising expedition

57°S – 10°N.
Cycling the longest mountain range in the world.
Self-funded, unaided and human-powered.
In aid of Lifebox.
The Expedition
Cycling the Andes, the longest mountain range in the world, from the wind-sculpted lands of Patagonia to the Caribbean shores of Colombia, we exchanged our cars and home comforts for bicycles and a tent. We would be exploring some of the remotest regions of the world while completely exposed to the elements. Fierce winds, high altitude, subzero temperatures and exhausting climbs awaited us.

We decided to take time out from specialty training to pursue this adventure, believing it would offer an immense platform for personal growth. Moreover, we wanted to use this fantastic opportunity to support the Non-Governmental Organisation (NGO), Lifebox.

Lifebox
Lifebox was founded in 2011 by Professor Atul Gawande and four of the world’s leading healthcare organisations with the principle aim of improving surgical safety in low-resource countries. Despite the advances in surgical safety in the developed world, in 2015 the Lancet Commission on Global Surgery highlighted the issue that five billion people lack access to safe, affordable surgical and anaesthetic care when needed.1 Lifebox provides equipment, education and support to hospitals with limited resources. They distribute pulse oximeters to allow implementation of the World Health Organisation surgical safety checklist, which has been shown to reduce the rate of death and complications by more than one-third.2 Their work has spread to over 100 countries, making surgery and anaesthesia safer for 10 million patients.

We were delighted to find an organisation that provides a simple, sustainable and pragmatic intervention that truly saves lives. Given the lack of awareness, even within our own specialty, it was clear that our adventure would be in aid of Lifebox. We have set an ambitious target to raise one pound per mile cycled, hoping to equip 50 operating rooms with pulse oximeters, improving surgical and anaesthetic safety for thousands of individuals.

The Strait of Magellan – an area of great historical exploration in Southern Patagonia. Our journey began 1,000km off the shores of Antarctica.
Personal Development

Interestingly, many of the personal skills required for a successful expedition are also highly applicable to a career in anaesthesia – skills such as organisation, planning and communication. We spent a considerable amount of time beforehand researching country profiles, seasonal weather, vaccinations, dangers, and equipment. While these preparatory steps seemed obvious, we had to develop new skills, for example, negotiating with companies for equipment sponsorship. We found that perseverance and a degree of resilience were essential and, although our learning curve was steep, it was certainly satisfying when we were successful.

The journey thus far has been an incredible experience. We have cycled through remote regions of Patagonia, surrounded by magnificent scenery of mountains and glaciers. We have truly felt the warmth of the Latin American people and we have gazed in awe as we camped under the star-filled skies of the Atacama Desert. Although spectacular, it has not been without its challenges. Our most testing time has been in Patagonia, where the combination of ‘the world’s worst weather’ and the remote wilderness took us close to our physical and psychological limits. The wind was so strong on occasions that we would be thrown from our bicycles, and even had to resort to pushing them downhill to make any progress. Yet, with immense stubbornness, we persevered. We began to process the experience, and felt not only a sense of accomplishment but also a sense of personal growth extending beyond the realms of a bicycle adventure. It provides the self-belief that during testing times you have what it takes to reach your goal.

Cycling the length of the South American continent has been incredibly difficult, but through these challenging experiences we have certainly grown. The skills we continue to develop are of paramount importance, since poor preparation, poor situational awareness or a lack of perseverance can lead to disastrous outcomes. We are more confident in our approach to tasks and more capable in dealing with adversity. Furthermore, this has been a great opportunity to combine a personal challenge with voluntary work in our chosen specialty. We hope that our adventure may inspire others to seek different ways to develop personally and professionally outside the realm of a specialty training programme.

References


FOLLOW THE PROGRESS OF THE JOURNEY AND DONATE TO LIFEBOX VIA FIFTY7DEGREESSOUTH.COM

“Investment in travel is an investment in yourself”

Matthew Karsten
Travelling vagabond. He has been exploring the world for six years and is a full-time adventure travel blogger and photographer.
THE NEW NATIONAL SAFETY STANDARDS FOR INVASIVE PROCEDURES: beyond the WHO Surgical Safety Checklist
The WHO Surgical Safety Checklist was introduced in 2009, and is now in use every day in virtually every operating theatre in the UK. Unfortunately, in 2016, avoidable harm continues to occur during invasive procedures.

The National Safety Standards for Invasive Procedures (NatSSIPs) aim to go beyond the 2009 WHO checklist,1 by embedding human factors in training and design, enhancing inter-professional team performance and so reducing Never Events and invasive error. The NatSSIPs standards were published by NHS England in September 20152 following a patient safety notice. They were written collaboratively by Medical Royal Colleges, training bodies and regulatory agencies, with the expectation that healthcare providers would begin to make them a reality by September 2016. Future inspections by the CQC to assess the safety of services are thus also likely to focus on their implementation.

An invasive procedure includes not only surgery, but any procedure where a hole is made in the patient’s body and where consent is usually required. For example, it includes endoscopy, acute medicine, interventional radiology, emergency medicine and cardiology (but not simple procedures, such as cannula or catheter insertion or blood tests).

The NatSSIPs document is based on learning from near-misses and national Never Events. It includes both
organisational standards and sequential steps in the patient pathway, with the organisational standards going beyond the immediate team to include the wider safety system. See Figure 1 for a summary of the Barts Health LocSSIPs standards. The sequential steps incorporate the five steps of the WHO Surgical Safety Checklist, but add three further sections (site-marking, prosthesis and implant verification, and prevention of retained foreign objects) to make up the ‘NatSSIPs 8’. The NatSSIPs document requires that specialties and teams agree their own local versions of the standards (LocSSIPs) based on the NatSSIPs. Teams should be engaged in writing their local standards and then follow them together, understanding their team’s ‘modus operandi’ by creating openness and an ongoing dialogue.

Like many NHS trusts, Barts Health is no stranger to Never Events, but we have taken action by actively supporting NatSSIPs implementation. We are using it as a systematic approach to Never Event analysis and prevention, and are expecting a wider safety improvement in the process. Benchmarking of services against the NatSSIPs framework can demonstrate the need to improve the organisational standards, as much as the sequential team steps and in line with the NatSSIPs document, gives everyone a role and responsibility, which goes beyond compliance. As most people don’t have time to read lengthy policies, we have created self-explanatory straplines for each of our local standards, along with one-page headlines to enhance engagement. Organisations must have systems that provide assurance that everyone knows the safe way to work. It is not good enough to say ‘The team did not use the Surgical Safety Checklist’, but more important to ask ‘Why not?’, and ‘Did team members have a local induction?’, ‘Did they help design their checklist?’, ‘Did the organisation feed back to the team about other near-misses and Never Events both locally and nationally?’ ‘Did the team have human factors team training?’

It is of course easy to write standards, but difficult to ensure that everyone follows them. That is why the strategy for implementation endorsed by NatSSIPs requires an approach that involves and listens to the whole team. When we consider other high-reliability industries such as the aviation, construction or nuclear industries, this is nothing new. It is known in industry that major accidents do not occur following a
unique set of events, but from the migration of the organisation and team to a state of risk over time. Harmonised, standardised practice based on learning and evidence, creates a shared mental model that reduces risk. LocSSIPs can allow for specialty-specific caveats, but the generic standard remains the same – for example, we have the same team verification process for the insertion of an artificial prosthesis or implant into a patient whether the procedure happens in ophthalmology, orthopaedic or cardiac theatres. We have a scheduling standard that does not allow laterality of a procedure to be abbreviated when booking a case or on a printed operating list, whether you are a professor of neurosurgery, a core trainee in vascular surgery or a general manager.

We are working closely with Will Harrop-Griffiths (consultant anaesthetist and Chair of NHS England’s National Safety Standards for Invasive Procedures Group) to spread the message of these important standards and make them a reality.

No one comes to work to harm patients, but without human factors design and system change, it is inevitable. The bottom line is that if you or a member of your family were having an invasive procedure, would you want to know that the NatSSIPs are being met? We know we would!

References

Pauline Grant, Dr Matt Wikner, Dr Will Harrop-Griffiths and Dr Annie Hunningher

Figure 1: The Standards

<table>
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<tr>
<th>SEQUENTIAL STEP STANDARDS</th>
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<tr>
<td><strong>THE NatSSIPs EIGHT</strong></td>
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<tr>
<td>1 Procudural verification of site marking</td>
</tr>
<tr>
<td>‘Correct procedure, on the correct site and side’</td>
</tr>
<tr>
<td>2 Team brief</td>
</tr>
<tr>
<td>‘Opening communication channels to plan safe care’</td>
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<tr>
<td>3 Sign in</td>
</tr>
<tr>
<td>‘Final safety check before anaesthesia’</td>
</tr>
<tr>
<td>4 Time out</td>
</tr>
<tr>
<td>‘Final safety check before the cut’</td>
</tr>
<tr>
<td>5 Prosthesis verification</td>
</tr>
<tr>
<td>‘Correct prosthesis, correct process, every time.’</td>
</tr>
<tr>
<td>6 Retained foreign objects</td>
</tr>
<tr>
<td>‘Nothing unintended left behind’</td>
</tr>
<tr>
<td>7 Sign out</td>
</tr>
<tr>
<td>‘Count and procedural conformation with planning for postoperative care.’</td>
</tr>
<tr>
<td>8 Debrief</td>
</tr>
<tr>
<td>‘What went well and how can we improve?’</td>
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<table>
<thead>
<tr>
<th>ORGANISATIONAL STANDARDS</th>
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<tbody>
<tr>
<td>1 Governance and audit</td>
</tr>
<tr>
<td>‘A safety culture and system that is proactive, as well as reactive.’</td>
</tr>
<tr>
<td>2 Documentation of invasive procedures</td>
</tr>
<tr>
<td>‘If it’s not documented, it didn’t happen.’</td>
</tr>
<tr>
<td>3 Workforce</td>
</tr>
<tr>
<td>‘Safe staffing at all times.’</td>
</tr>
<tr>
<td>4 Scheduling and list management</td>
</tr>
<tr>
<td>‘A planned list with clear information enables safer care.’</td>
</tr>
<tr>
<td>5 Handovers and information transfer</td>
</tr>
<tr>
<td>‘Optimise patient handover, optimise patient care.’</td>
</tr>
<tr>
<td>6 Local induction*</td>
</tr>
<tr>
<td>‘Dedicated time, dedicated staff, structured and comprehensive.’</td>
</tr>
<tr>
<td>7 MDT team development*</td>
</tr>
<tr>
<td>‘A team of experts is not an expert team.’</td>
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*Two extra standards at Barts Health for education and sustainment of standards.
CELEBRATING 170 YEARS OF ANAESTHESIA

Dr Abigail Whiteman
Consultant in Anaesthesia, UCLH

21 December marks the anniversary of the first public demonstration of surgical anaesthesia given in Britain: the foundation of our profession in this country. For 170 years, anaesthetists have been rendering patients insensate and pain free, and increasingly ensuring their safety to effect a surgical cure.

The discovery of the anaesthetic properties of ether marked a turning point in the history of surgical procedures, as it enabled administration of a chemical agent to render a patient unconscious of surgical pain. Prior to this, the unsuccessful techniques of mesmerism and nitrous oxide had been used. The first public demonstration of ether was performed on 16 October 1846 at Massachusetts General Hospital, Boston. Dr William Morton administered ether to Gilbert Abbott with the intention of ‘producing insensibility to pain’ for the removal of a vascular tumour from his jaw. The operation was successful and the surgeon, John C Warren, announced to the amazed spectators ‘Gentlemen, this is no humbug!’ After four successful operations, Morton’s use of ether was presented at the Boston Society for Medical Improvements, and then published in the Boston Medical and Surgical Journal, from where the news of ether spread globally!
In the UK, the English dentist James Robinson administered ether for removal of a diseased molar tooth from a young female patient. This procedure was carried out in a house in London owned by Dr Francis Boott, which is now marked by a blue memorial plaque. Boott wrote a letter about the effectiveness of ether to his friend Robert Liston – widely considered to be the best surgeon of his day. Unlike many of his colleagues, he believed excessive pain and excessively long operations were cruel, so much so that he was commonly quoted as saying ‘Time me, gentlemen, time me’.

The first public demonstration of surgical anaesthesia in England was performed, on 21 December 1846, at London’s University College Hospital (UCH). The building, known as the Cruciform Building, now forms part of the University College London medical school and library. The surgery performed was a leg amputation on patient Frederick Churchill, a butler whose broken leg had been left to fester over some time. His case notes, published by UCH in celebration of the event, record the surgeon as Liston but do not mention the anaesthetist. Accounts of the event record the anaesthetist as Mr William Squire, a medical student and nephew of the apothecary who supplied the ether.

The painting by Ernest Board on the opposite page depicts the likely scene within the operating theatre, with some artistic licence. With the scene set, Liston declares to the watching audience ‘Gentlemen, I am now going to try a Yankee dodge for making men insensible’. William Squire is thought to have used an instrument, the lower vessel of a Nooth apparatus, to administer the ether. He then alerted Liston that the patient was ready and 26 seconds later the amputation was over. On awakening, Churchill, not knowing the operation was over, called out, ‘Take me back, I can’t have it done!’ Liston, is reported to have announced to the audience, ‘Good God! Why it’s better than mesmerism’. He is famously quoted, in the People’s Journal in early 1847, as saying ‘Oh what a delight for every feeling of heart to find the New Year ushered in with the announcement of this noble discovery of how to steal the sense of pain and veil the eye and memory from all the horrors of an operation. We have conquered pain!’

The advancements within anaesthesia since this first demonstration have been vast, ensuring successful and safe anaesthesia in the face of increasing surgical ambition. We have effective drugs with quite incredible pharmacokinetic profiles and yet with minimal side effects. Our monitoring allows us not only to monitor exhaled carbon dioxide and oxygen saturations but to respond to beat-by-beat estimations of blood pressure and cardiac output. Our ventilators have progressed from a pedalling medical student to state of the art, responsive computers. Most importantly, we now exist in a patient-centred culture where patient choice and patient safety influence every decision we make. If we have progressed from the Squire inhaler to this in 170 years, one can only feel positive about what the next centenary may bring.

References

3. Cock FW. The first operation under ether in Europe—the story of three days. University College Hospital Magazine 1911;1:126–144.

All images courtesy of the Wellcome Collection.
One aspect of the College’s new organisational strategy is to improve its use of technology. Under the Technology Strategy Programme, you will see a range of improvements for our membership, staff and those we support. Aaron and Jamie from the Technology Strategy Programme introduce themselves.
We will have a range of new systems which better support our fellows and members at every stage of their career, with easy to use, integrated tools helping their learning and development. Online collaboration technology will help us work in smarter and faster ways from different locations. Through digital platforms, we will better champion anaesthesia, support our patients, inform the public and educate the media. New ‘big data’ systems will bring together our wealth of organisational information and help inform decisions which improve the quality, safety and standards of anaesthesia provision.

Having joined the College in May 2016, I have been struck by how enthusiastic and well informed members are about technology. This is a great position to be in, and means that the team and I can work directly with you, to define and deliver new systems which reflect what you really need. I would love to hear about any ideas you have for the Technology Strategy Programme, or if you would like to be involved in helping shape it. The team and I can be reached at tsp@rcoa.ac.uk.

I’m very excited to be taking an Out of Programme Experience (OOPE) as the Technology Strategy Programme Fellow, specifically working on the areas of College technology that support life-long learning for members. The area with the most pressing need, and one which has a particularly poorly rated system, is the trainee e-portfolio. Work is well underway to consider its future and how it best addresses training needs, and to provide you all with a better user experience to support training and learning.

Additionally, we are thinking more widely about how other tools to support life-long learning integrate with the e-portfolio (for example a logbook). We started this process in August and September 2016 with a series of user-experience workshops. I am grateful to the fellows and members who attended [and used up a fair amount of post-it notes!].

There will be change to come over the next 12 months, and we will communicate our plans widely. If you have any questions or comments, then please do get in touch via tsp@rcoa.ac.uk.
Pom Down Under

Perioperative Medicine in Australia and New Zealand

Professor David Story
Chair of Anaesthesia, University of Melbourne, Australia

Dr Sean McManus
Senior Specialist, Department of Anaesthesia, Perioperative Medicine and Intensive Care, Cairns Hospital, Australia
While Australia and New Zealand are different countries (and sporting rivals), unified specialist medical Colleges cover both sides of the Tasman Sea. The Australian and New Zealand College of Anaesthetists (ANZCA) has been studying and developing perioperative medicine for over a decade with the primary aim of improving patient care.

For a number of years perioperative medicine has been one of seven ANZCA clinical fundamentals, and is examined in the Final exam. Recent advances such as the RCoA’s Pathway to Better Surgical Care and the American Society of Anesthesiologists Perioperative Surgical Home website have fuelled both enthusiasm and debate due to growing awareness that extending perioperative medicine is a vital part of the future of our profession. The debate stems from the fact that many ANZCA fellows are interested in perioperative medicine, but only a minority are interested in extended ward clinical care, which is leading to concerns about enforced practice change.

ANZCA has formed a Perioperative Medicine Special Interest Group (SIG) that meets and presents both at the College Annual Scientific Meeting and at a popular free-standing SIG meeting in (sunny) Queensland. This meeting aims to engage with other specialties exemplified by the 2016 meeting being co-hosted with geriatricians from the Royal Australasian College of Physicians. Another important aspect is that the Clinical Trials Network is part of ANZCA. This allows a closer relationship between those driving the education (and political) agenda and those providing supporting evidence around clinical and cost effectiveness in perioperative medicine.
SUSTAINABLE PROGRAMMES WILL REQUIRE CONSIDERABLE MANAGEMENT AND LEADERSHIP SKILLS

Both Australia and New Zealand have very strong public hospitals and government-supported community care. However, in Australia over 50% of elective surgery occurs in private hospitals. Individual surgeons have substantial influence in these hospitals and choose which anaesthetists they work with in ways that, at their worst, can be predatory. Funding is from a mix of government insurance, private insurance, and out-of-pocket expenses. Many surgeons also engage with individual specialist physicians, often cardiologists or nephrologists, who use the title ‘perioperative physician’. While this arrangement in private surgery is likely to be superior to surgeons proving sole perioperative care, the clinical and cost effectiveness is unclear. A training feature that causes concern is that the Royal Australasian College of Physicians has neither a perioperative medicine curriculum nor an examination. Further, like (internal medicine) physicians everywhere, physicians in Australia and New Zealand have limited understanding of anaesthesia and anaesthetists, with ongoing helpful comments about avoiding hypoxia and hypotension and suggesting spinal anaesthesia. Problems with the private surgeon-physician model were highlighted in a South Australian coronial report on the case of two patients who died after elective surgery in a small private hospital. The Coroner was particularly concerned about poor communication about known preoperative patient risks. To succeed in Australia and New Zealand, perioperative medicine will need collaboration between anaesthesia, surgery, general medicine, ICU and general practice, with good communication at the core.

In 2015 ANZCA formed a working group to look at the future of perioperative medicine in our part of the world. A key finding was that given current ANZCA training, curriculum and exams, all ANZCA fellows should be regarded as perioperative medicine practitioners. However, a minority could choose to go on to become perioperative medicine specialists, and the question is how best to achieve this. A long-term approach might be to have a separate Faculty of Perioperative Medicine, as ANZCA [and RCoA] has for pain medicine. As with the Faculty of Pain Medicine, a Faculty of Perioperative Medicine would allow greater ability to provide an extensive training programme for those from other specialist colleges. A Diploma would, however, be an effective and testable precursor to a Faculty and could still involve cross-College engagement and accreditation. Underpinning all this, the question arises of curriculum content and examination for training perioperative medicine specialists. Australia and New Zealand already have established university-based qualifications in perioperative medicine, and collaborating on mutual recognition will be important. These, however, lack supervised clinical training, which is where the specialist Colleges can provide the structure for comprehensive advanced clinical training as part of a well-rounded curriculum.

Determining perioperative medicine training components will best be done through international collaboration. Specialist skills may include cardiopulmonary exercise testing; secondary disease prevention following complications; advanced care directives; management, finance, system change and implementation science; as well as public health practice in areas such as smoking cessation, diet and exercise. Local topics will also include: regional and remote location perioperative medicine, including expanding the role of GP anaesthetists; and perioperative care of indigenous peoples.

Small-scale experience with perioperative medicine programmes in Australia and New Zealand suggests that sustainable programmes will require considerable management and leadership skills. Anaesthesia-led perioperative medicine could be seen as a disruptive innovation where there is a ‘market’ need, but working with the (at times underperforming) current providers will require diplomacy.

References
DISTANCE – SKILL – DECAY

CHALLENGES IN PAEDIATRICS FACED BY DISTRICT GENERAL HOSPITALS

In recent times, the NHS has seen a strong push towards the centralisation of healthcare, and paediatric services have fallen in line accordingly. Today, the majority of elective paediatric surgery is provided at specialist tertiary units and, as a consequence, anaesthetists at district general hospitals have fewer opportunities to maintain their paediatric airway skills. We present our perspective from a district general hospital, and reflect on how de-skilling, secondary to centralisation, could compromise the safety of our future patients.

West Suffolk Hospital is a 430-bed district general hospital in the East of England. The Anaesthetic Department consists of 28 consultants, all of whom primarily work with adult patients. Outside elective operating hours, two resident on-call trainees provide theatre and intensive care cover, with support from two non-resident on-call consultants at home. When a sick child is anticipated to require emergency intubation, at least one

Dr Nancy Wang
CT2 Anaesthetics, West Suffolk Hospital

Dr Ayush Sinha
Consultant Anaesthetist, West Suffolk Hospital
consultant is usually informed, and if time permits, intubation is delayed to await their arrival. Intubated children are usually managed in the adult intensive care unit until the Children's Acute Transport Service arrives to retrieve them to a tertiary paediatric centre.

Our study
We examined the case records of 40 emergency paediatric-intubation patients over a three-year period. There was an increase in the number of cases over time, with 70% of cases occurring overnight, at weekends, or on bank holidays, when consultant support was potentially 30 minutes away (Figure 1). There was an opposite downward trend in patient age, with the average child being only eight months of age in the most recent year (Figure 2).

Intubation was successful in all 40 cases, but there was a staggering 10% difficult intubation rate (four out of 40 cases). Two of these difficult intubations were performed by a trainee, because the pressurised situation did not allow for a delay of the procedure until the arrival of the consultant. There was also a 30% incidence of re-intubation, with inadequate airway seal being the most common indication.

Our reflections
Through good team-work and a modicum of luck, we have had no failed paediatric intubations. However, our high incidence of difficult intubation (10% compared to an estimated 1.35% in the general paediatric population\(^4\)) and frequent re-intubations, indicate that as a group, our technique and confidence in managing paediatric airways are sub-optimal.

Within healthcare, ‘distance decay’ describes an observed correlation between patients’ health outcomes and their geographic proximity to a tertiary hospital.\(^3\) While the causes are likely to be multifactorial, clinical limitations of the district general hospital team could play a role. With elective paediatric surgery being almost exclusively provided by our tertiary centres, most of our anaesthetists no longer routinely intubate young children. Unfortunately, the reality remains that children who fall ill in the community will often still attend their nearest emergency department, irrespective of the type of hospital it is. With the increasing number of unplanned paediatric intubations at West Suffolk Hospital, we feel that measures must be taken to prevent further de-skilling with time.

Our considerations
One radical solution would be to push centralisation to the extreme and remove all paediatric services from the peripheral hospitals. In doing so, sick children would be admitted directly to a tertiary centre, bypassing the district general hospitals and rendering the problem with clinician de-skilling moot.
Unfortunately, this would have knock-on effects for other specialties (e.g. neonatal care in obstetric services) and distance decay would be exacerbated with more children potentially dying before they reach a hospital.

Another possibility is to resist centralisation and aim to retain a higher proportion of paediatric surgery in district general hospitals. However, this is not a cost-effective approach and would be difficult for many small hospitals to accommodate.

A more balanced strategy in tackling de-skilling would be to facilitate supernumerary attachments to tertiary hospital paediatric surgical lists for non-paediatric consultant anaesthetists. This strategy would reflect the recommendation in the RCoA’s ‘Guidance on the Provision of Paediatric Anaesthesia Services 2016’, which also highlights the fact that the Certificate of Fitness for Honorary Practice is conveniently set-up to allow this arrangement, and that such activities are an important component of continuing professional development in paediatrics. This approach has minimal effects on patient care or interdisciplinary activities within hospitals, but still offers the opportunity for anaesthetists to refresh their paediatric skills on a regular basis.

**Final remarks**

Stabilising critically ill children is a stressful business, but long-term outcomes are heavily influenced by the initial resuscitation. During our study, we observed an increase in the number of sick children we manage in a district general hospital. However, we also gained insight on how centralisation and the loss of paediatric experience are affecting our skills. We hope that in discussing our perspective, colleagues who are in similar situations will share our reflections and prioritise their continuing professional development in paediatrics to safeguard the lives of their future patients.

**References**

Frail and elderly patients often fail to return to baseline levels of health and activity after major surgery. By 2030, Europe will have one person over the age of 65 years for every 2.6 between the ages of 20 and 65.

By 2050 there will be 71 million over 80, compared to 34.6 million today. The largest percentage growth will be in Latin America, where the number above 80 will rise from 10 to 45 million, and Asia: 60 million to 256 million. Around 20% of the over-80s will be frail.

Frailty is one of three overlapping syndromes: sarcopaenia, cachexia and frailty. Frail patients are less able to respond appropriately to stress and persistently elevated inflammatory proteins. They have a ‘decreased physiologic reserve across multiple organ systems with impaired homeostatic reserve, reduced capacity to withstand stress and resultant adverse outcomes’.

Describing and understanding risk
Postoperative outcome has conventionally been measured from a short-term perspective, such as 30-day mortality, but is this all that a ‘reasonable patient would want to know’ if they are at risk of long-term impairment?

Major surgery may prolong life, but postoperative morbidity increases mortality for the following three years. Understanding appropriate patient-related outcome measures, including the risk of dependency, limitation in the activities of daily living, or change in residency from own home to long-term care facility are important for informed consent and planning.

Most cancer treatment outcomes are expressed as percentage survivals at certain dates rather than cures, while changes in quality of life are poorly described. Elective aortic aneurysm repair involves surgery where patients risk morbidity and mortality to avoid a rupture that has not yet happened.

Weighing up risks versus benefits is challenging for patients and doctors, especially when the balance changes as populations and techniques develop.

Long-term follow up requires a comparison with preoperative status and allowance for the changes that would have occurred over time regardless of surgery. Population norms may help, and longer-term recovery assessment tools are available. A comparison against patients with similar underlying illnesses, organ dysfunctions or frailty who had not needed surgery would be useful, but complex.

Impact of surgery on organ function
Complications that affect brain or renal function are examples of organ dysfunctions that have a high impact on survival and quality of life. Patients with
acute kidney injury or acute-on-chronic injury may fully or partially recover, but for some frail patients, once renal failure occurs, renal replacement therapy will be deemed inappropriate, so overall duration of survival will be reduced.

Anaesthesia and surgery adversely affect brain function in some elderly patients. Delirium is associated with increased mortality and institutionalisation. Postoperative cognitive decline is associated with disruption of the activities of daily living, quality of life and inability to work. Unfortunately, routine assessment of brain function prior to surgery is lacking, and so large-scale follow up and comparison against those not having surgery is difficult.

**Conclusion**

Long-term ongoing data collection presented in an understandable format is vital, and the Perioperative Quality Improvement Programme is working towards improved long-term follow up. Inclusion of the elderly in research has been deficient in the past, but will be essential in the future. The ability to collect meaningful patient-related outcome measures will provide impetus towards the development of drugs, organisation and clinical techniques in the perioperative care of the older or frail surgical patient. Most importantly, it will help to inform decision making and consent by improving prediction of survival and, especially, quality of life.

**References**

In 2015 the Royal College of Anaesthetists launched its vision for the future of perioperative medicine. This vision centres on the continuing evolution of anaesthetists into the role of perioperative physicians, overseeing and coordinating the care of high-risk patients throughout their entire perioperative journey from the time of contemplation of surgery through to discharge from hospital.

Whilst many anaesthetists already have the skills and knowledge to provide effective perioperative care for surgical patients, and aspects of perioperative medicine already exist in both the training and FRCA syllabuses, it is clear that, in order for a successful, anaesthesia-led model to be implemented, it is necessary to provide specific training in order to equip the next generation of consultant anaesthetists with the skills to deliver perioperative medicine services.

In August 2016 the RCoA updated its curriculum to include compulsory units of training in perioperative medicine at basic, intermediate and higher levels of training.

Accompanying these changes, a wave of interest in and enthusiasm for perioperative medicine has developed amongst trainees in anaesthesia, many of whom have begun to seek out available educational resources to help them meet their now mandatory training needs.

However, open-access educational resources remain disparate and limited. In order to address this, we are developing, and seek participation in, a trainee-led and delivered educational collaborative called ‘Trainees with an interest in perioperative medicine (TRiPOM)’.

It is generally acknowledged that modern surgical care and the practitioners delivering it must evolve in response to the ever-changing needs of our increasingly complex surgical population. Perioperative medicine has developed both as a concept, and as a medical specialty in direct response to this need.
Interest in Perioperative Medicine (TriPOM), to provide high-quality, interactive training resources for doctors wishing to train in perioperative medicine from any parent specialty.

TriPOM aims to develop a range of open-access educational resources in conjunction with trainees in anaesthesia and other specialties, including surgery and medicine. Core content, aligned with training curricula, will be delivered across several platforms, including a website, Twitter, YouTube and email. Current content includes a monthly perioperative medicine ‘journal watch’ and Journal Club summaries from anaesthetic departments across the country. A monthly tutorial (POMTOM) will also feature prominently, the first one to be released next month. These tutorials will be curriculum linked.

When developing TriPOM, we recognised that a large amount of quality educational activity occurs weekly in individual departments across the country. We felt that we could offer a network and platform for wider dissemination of these efforts for the benefit of trainees (and consultants) in the wider community. Should you wish to host a Journal Club on a perioperative medicine topic, then please contact us and we will be very happy to facilitate.

Currently, numbers of fellowships in perioperative medicine are growing nationally. The experience gained on these fellowships is quite disparate, and no central database of these opportunities exists. Additionally, due to local demands on service and structure, the clinical development and delivery of perioperative medicine varies according to the specific environment. The TriPOM website will include summaries of current fellowships in perioperative medicine, written by fellows. We hope to create a network of fellows engaged in these and other educational posts, for sharing educational material as well as experiences of developing and delivering perioperative medicine working with local populations and resources. We would be very keen to gain engagement from both perioperative medicine fellows and perioperative medicine leads in departments across the country in developing this resource.

TriPOM is currently creating a network of regional leads amongst trainees to co-ordinate local activities and meetings. We will be attending and hosting regional study days, as well as hosting a standalone TriPOM meeting in 2017. Similarly, we will act as a hub for information on forthcoming meetings and formal educational opportunities in perioperative medicine. Our launch meeting was held as a breakout group at EBPOM 2016 in July this year. We heard from current perioperative fellows from across the country about their experiences, as well as from Professor Mike Grocott on training in perioperative medicine. Footage from these talks will be available online in the next month.

Since TriPOM is designed to be community driven, your ideas, input and enthusiasm are essential for our success.

We are currently seeking enthusiastic trainees and trainers to engage with us in developing our core content. If you would like to contribute, be it with a Journal Club, a blog, a vlog, or a tutorial, or simply by joining our mailing list, then please contact us at tripomgroup@gmail.com and follow us on twitter @tripperioperati1.

References

IF YOU WOULD LIKE TO CONTRIBUTE TO TRiPOM PLEASE CONTACT US AT TRIPOMGROUP@GMAIL.COM
A CHANGE IN HEALTHCARE

Understanding the change process and learning to build a case for change in healthcare.

Dr Sonali Thakrar
ST7 Anaesthesia
Management Consultant, PA Consulting Group

It came as quite a surprise to many of my colleagues when I told them that I’d be taking time away from anaesthesia to work as a management consultant.

"Why would you do that?" they asked. Well, let me explain. As a medical practitioner, change occurs continuously all around me.

Change to the research and evidence base is continuous, and thus the acquisition of the knowledge and expertise needed to achieve competence is also an ongoing task, as is the work on audit and quality improvement change processes that enable improvement in care. Beyond my immediate sphere of working, there is continuous change in terms of the economic, financial and political factors that influence healthcare as we know it. One can choose to support and participate in change, to ignore it, or to be indifferent towards it. I chose to study change in a truly dynamic manner – by learning hands-on to be adept in change management by becoming a management consultant.

Management consultancy is the practice of helping organisations to improve. This might be by improving performance, by creating value, by increasing growth, or by other means. Ultimately management consultants deliver change through a process involving analysis and diagnosis of a problem, visioning methods to tackle the problem, planning and implementing change, and evaluating the outcome.

Managing change is complex, and the idea of ‘embracing change’ requires a shift in thinking and approach – ultimately a change in culture. The reality of change within healthcare is that often it is imposed, and that the priorities for
those originating the change may not be aligned to those of key implementers, e.g. the clinicians. There can be a number of initiatives running at the same time and, again, prioritisation can mean that some initiatives are overtaken by others. With an array of initiatives, it is also easy to lose sight of objectives.

In healthcare in particular, change is communicated by a management team, and people act in response to the plan. Traditionally, the change originates with the executive board and management teams, and this is filtered down to directorates and clinical staff. Healthcare organisations, however, need to move away from this hierarchical approach and harness the power of the individuals fundamentally implement change, by appointing them as leaders. To enable successful and sustainable change there needs to be engagement of people at all levels, as well as a balance of driving change forward by visioning, structuring and directing the process, and allowing the freedom that will inspire people to adopt a new culture and way of thinking.

When an opportunity for change is identified, a case for the change is built, and a vision for the future is defined by change leaders from any hierarchical level. A change leader is essential to the success of the delivery of change, and has the responsibility for making change happen by ensuring commitment, and therefore the ultimate sustainability of the change. Identifying a change leader is often the missing link for sustainability of change within healthcare.

There are challenges likely to be encountered when delivering change. The barriers to accepting change and the qualitative and quantitative benefits need to be explored. A strategy will be developed, which includes an overview of the change and how it fits into the bigger picture, in particular how stakeholders’ concerns and needs are addressed and how the solutions required to resolve them will be developed.

Within the strategy, an outline and assessment of the resources and finances required for successful delivery of change need to be considered. These requirements are sometimes neglected but they could have a considerable impact on the sustainability of change.

Part of the strategy also has to be the answer to the question “How do you motivate people to change?” Much of this comes from an understanding of the stakeholders and from defining the impact that change will have on them as individuals. Understanding their usual behaviours and exploring barriers is paramount. Engaging people and allowing them ownership of change ensures that it is taken forward and embedded into culture. When there is a unified approach to change, it is most likely to succeed.

Anaesthetists are inherently suited to being change leaders. We form the single largest hospital medical specialty and have an array of skills essential for this role. Anaesthetists engage daily in multi-faceted team working, and our people and communication skills need to be exceptional, as much of the time we function in a time- and risk-pressured atmosphere. Despite this, it is difficult at times to step back and look at change thoughtfully, with the organisation’s imperatives for change in mind.

I believe a hands-on approach, by means of time in management consultancy, will provide me with a holistic understanding of the change process, and also the elements essential for building a case for change and making it successful and sustainable.

References
ANAESTHESIA IN EAST AND SOUTHERN AFRICA

The number of physician anaesthesiologists in East and Southern Africa is painfully inadequate. Could Fellowship training open up training capacity and accelerate growth of numbers?

Dr Farai Madzimbamuto
University of Zimbabwe College of Health Sciences

In 2015 the World Health Assembly unanimously approved a resolution to strengthen surgery and anaesthesia globally, as an important and cost-effective way to improve healthcare in low resource countries.

There are high levels of unmet surgical need in low and medium income countries, with a corresponding need for scaling up training of specialists in the region. Countries in East Africa (Kenya, Uganda, Tanzania) and Southern Africa (Zimbabwe) have had MMed [Master of Medicine] specialist training for Physician Anaesthetists [anaesthesiologists] for decades. Zimbabwe has trained 80 MMeds and 150 Diplomates in Anaesthesia since 1986, for a population that has risen from 8 to 15 million in that time. The MMed programme in Kenya has trained 145 specialists since 1978, for a population that has grown from 15 to 46 million. The training takes place in major urban hospitals, and specialists remain in those environments when qualified. Several countries in this region (Namibia, Botswana, Malawi, Zambia, Rwanda) have recently started or are about to start their own MMed programmes. There is limited capacity to increase training substantially to meet the need for anaesthesia services and for leadership of the specialty in the region.

Training through the Fellowship route is well established in South and West Africa, with a large gap in East, Central and Southern Africa (ECSA). Eleven countries form the intergovernmental East, Central and Southern Africa Health Authority in this region. Through this authority, several colleges have been or are being established to accelerate and standardise
specialist training across the region. One of the most successful is the College of Surgeons (COSECSA), which examines over 80 candidates at a sitting. In 2014 the College of Anaesthetists (CANESCA) was established, with plans to commence training as soon as a framework could be established, hopefully by 2017/18. A priority would be the provision of training in a wider variety of clinical settings, and not just in central teaching hospitals. These clinical settings could include the private sector, where colleagues are enthusiastic to enroll as trainers. They could also include provincial hospitals, which in many countries do not have specialists in posts. They are therefore often less equipped to manage more complex cases which are referred to them from district or mission hospitals.

Anaesthesia in low-income settings is often provided by non-physician anaesthetists, such as nurses or clinical officers who have had 12 months or so training in this field. With the establishment of provincial hospitals as specialist training sites, these hospitals would be better able to handle more complex surgery, usually beyond the scope of mid-level health workers. In some provincial hospitals in Zimbabwe where there are specialist surgeons, senior registrars, and COSECSA trainee surgical staff, the case mix is evolving to reflect the skills available. Patients benefit from services being provided closer to areas of greatest need, reducing travel time, costs and time-to-treatment, with improved closeness to home and family. Medical leadership and supportive supervision in anaesthesia enable mid-level anaesthesia staff to perform more cases with higher confidence, with the added benefits of decentralising training and experience to lower-level hospitals. We already have some mission or district-level hospitals, that ‘punch above their weight’ through access to resources or staff but that are outside the current training framework.

There is a long history of trying to bring training closer to where the workforce is needed. The familiarity with local dynamics of the health system makes it easier to focus early on finding local solutions. The MMed programmes themselves were originally premised on these advantages. Although a significant number of qualifying specialists have been lost over the years, in Zimbabwe enough have stayed in place for a community to emerge that is engaged in addressing local issues.

The pressure to devolve training is coming from another direction. Due to population growth and rural-urban migration, what were small rural centres and small towns decades ago are becoming significant provincial population centres. Colleges and universities are being established in these centres, although establishing a medical school (with anaesthesia departments) and postgraduate programmes are largely beyond local resources. A Fellowship programme would assist anaesthesia services (including training infrastructure) to develop without waiting for the establishment of an academic department.

Several member countries, such as Malawi and Zambia receive substantial international support for their MMed programmes while they are getting started. Being part of the College should also assist their programmes through access to regional rotations not locally available and through participating in regional examinations. The World Federation of Societies of Anaesthetists and several colleges, such as the Royal College of Anaesthetists, the College of Anaesthetists of Ireland and the College of Anaesthetists of South Africa have given very strong support. This support is critical for the success of CANESCA, and for strengthening anaesthesia services in East Central and Southern Africa.

References

Coffee-room rants

“If you have time to whine and complain about something then you have the time to do something about it.”

Anthony J. D’Angelo

Dr George Collee
RCoA Council Member

Dr John-Paul Lomas
RCoA Council Member
One of the many functions of the Royal College of Anaesthetists is to improve standards of healthcare, not only in those aspects that directly pertain to the work of anaesthetists, but also in the wider sense of helping to shape the future of the NHS.

As a result, the senior officers of the RCoA spend a large amount of their time reading the many documents that pass across their desks from government offices, regulators, other Colleges and interested groups who send out their well-intentioned plans ‘for consultation’. It is a time-consuming process.

It is striking how little critical observation comes to the College from the fellows themselves. Most of us are fairly well practised at making astute observations in the coffee room about what we think is wrong with the NHS, but few of us apply ourselves to helping to sort out the problems. Is this because we feel powerless in such a large specialist group as anaesthesia and such a large organisation as the NHS? If so, please consider the following routes by which you can influence decision making in medical politics, because every fellow and member of the College has a voice, and, via the President of the RCoA, that voice can be heard at ‘top table’ in government.

The most obvious place to start is the College website, which carries links to all the College Committees together with the email addresses of their chair.1 For example, if you have suggestions on how you think the College can better support your revalidation and appraisal, comment can be sent directly to the Chair of the Revalidation Committee.

The College is sometimes criticised for being too distant from the clinicians whom it claims to represent, so please do play a part in addressing that problem.

Get in touch!

For suggestions pertaining to more local matters you might contact your Regional Advisor or seek a response from any of the 24 elected Members of the College Council, any of whom can be asked to raise a matter either within the mechanisms of the College, or for discussion at one of the monthly Council meetings.

The College is sometimes criticised for being too distant from the clinicians whom it claims to represent, so please do play a part in addressing that problem.

CONSIDER THE ROUTES BY WHICH YOU CAN INFLUENCE DECISION MAKING – EVERY FELLOW AND MEMBER OF THE RCoA HAS A VOICE

If you prefer a more public forum there is the letters page of this Bulletin open to you or, if you have joined the social media revolution, the College’s Twitter presence is ever-expanding. Even the most time-pressed coffee room politician should be able to fire off 140 characters to @RCoAPresident.

Trainees are given a voice via the Anaesthesia Trainee Representative Group, with two elected representatives on Council and a Trainee Committee to ensure the trainee voice is heard loudly within the walls of the College. To find out who your trainee representative is, contact trainee@rcoa.ac.uk, the first point of contact for any trainee-related issues at the College.

There has never been a more important time to be engaged in shaping the future of our specialty and our profession. The College is the voice of the specialty to the outside world, but its voice is only as strong as that of the fellows and members it comprises. We implore you: talk to us so we can talk for you.

References
1 College Committees Matrix (www.rcoa.ac.uk/node/2994)
Myth, like denial, is central to human existence. Myth tells us what we could have been. In this century the most influential mythmakers have been moviemakers.

Dr David Zuck, History of Anaesthesia Society

The so-called ‘Hollywood dream factory’ has inspired, educated, frightened, and entertained us. It has shaped how we think about ourselves and those around us by reinforcing old stereotypes and creating new ones. I’m almost ashamed to say that this book is the product of thousands of hours of movie watching and reflecting on how the medical profession is and has been seen by those we serve. It is not a history of medicine, but rather a look at the way movies have mirrored the changes in medical care and in society’s attitudes towards doctors, ranging from laudatory to highly critical.

During our sixty-year tour of medical movies we will encounter many recurring events and themes that screenwriters would have us believe are part and parcel of medicine. As one cine-historian wrote, ‘Few groups have been so consistently distorted and maligned by Hollywood as the medical profession,’ and he listed among the stereotypes ‘the dedicated research scientist, the inhumane quack, the Lothario with pretty nurses and other men’s wives, the flashy plastic surgeon, the Park Avenue psychiatrist, the crazed creator of monsters, the bumbling country practitioner with a heart of gold, and the brilliant young intern who puts his stodgy superiors to professional shame.’ But it is important to note that criticism of doctors is as old as history. In 1902 medical education was such that William Root, a medical student at the University of Chicago, started AOA (Alpha-Omega-Alpha: see Wikipedia), and it took the Flexner report in 1910 to establish uniform professional standards in medical training.

The earlier films discussed were made during the period that has been called the Golden Age of Medicine, when doctors attained an unprecedented admiration for their work; public opinion polls consistently ranked physicians among the most highly admired individuals. Medical practice was associated with the miracles of science, and the profession attracted few adverse comments. Although not all movie doctors were paragons – some were arrogant egotists, handsome womanizers, and villains – yet of the physicians who appeared in four
hundred films made during 1949 and 1950, in only twenty-five were they portrayed as bad people. Images that predominated were the earnest Doctor Kildare, the kindly Doctor Christian, and the driven scientist Arrowsmith, augmented after the arrival of television by such sympathetic figures as Marcus Welby and Ben Casey.

The second half of the films discussed were made during medicine’s fall from grace, which was due in large part to its successes. Acute life-threatening diseases declined, health status improved greatly, and a generation that hardly knew serious illness came increasingly to view good health as a right rather than a fragile blessing. Meanwhile, the bond between patients and their physicians weakened, as doctors no longer made house calls, or saw patients in surgeries in their own residences; hospitals became the principal venues for medical care. Although spectacular advances continued, as in the treatment of once fatal leukaemias and lymphomas, most of the new developments, cardiopulmonary resuscitation, kidney dialysis, and the proliferation of intensive care units, were more widely applied to prolonging the life of the terminally ill. The backlash is shown in Sidney Lumet’s angry 1997 film Critical Care, which shows ICUs as places where unscrupulous doctors keep insured terminally ill patients on numerous life supports in order to run up exorbitant bills. Society’s concerns about the introduction of transplants are reflected in films like Coma and Extreme Measures. Furthermore, the opposition of the American Medical Association to what it called ‘socialised medicine,’ Medicare and Medicaid, until it reached a lucrative agreement with the government during the 1960s, resulted in a decline in its image to the point where in the 1971 film The Hospital it was referred to as the ‘American Murder Association.’

As the new millennium dawns medical care is in the midst of cost-cutting changes, the reigning philosophy being ‘managed care.’ The 1998 Academy Award winner As Good as it Gets, is highly critical of managed care. By contrast, the very professional gray-haired doctor who makes a home visit to treat an asthmatic child is as positive an image as any movie doctor in the ‘Golden Age.’

I am most grateful to Dr Dans for permission to quote from his book, Doctors in the Movies: Boil the Water and Just Say Aah (Medi-Ed Press, Bloomington, Illinois, 2000). It contains reviews and cast lists of some 75 films featuring the medical profession from the 1930s to the turn of the century, and has chapters in which the changing face of medicine is discussed. But there are gaps. When challenged about the absence from the book of the only movie ever made about the origins of general anaesthesia, the little known The Great Moment (Preston Sturges, Joel McCray, 1944 – for information about which I am indebted to my friend Professor Alan Dronsfield), Dr Dans’ two reasons for the omission were that Morton was not a doctor but a dentist, and that the film is seriously flawed, which it certainly is. Also missing is the outstanding British Green for Danger (1946), although Dr Dans generously forwarded an enthusiastic review which he had written some years after the book was published. Not to be missed among medical films are The Citadel; MASH; The Hospital (with our own Diana Rigg); One Flew Over the Cuckoo’s Nest; the Romanian film The Death of Mr Lazarescu (2009 (labelled as a black comedy!)); and, as a tongue-in-cheek, cliché-ridden attempt to restore the good doctor to his pedestal, Doc Hollywood (1991).
EVENTS CALENDAR

Further information about all of our events can be found on our website.

events@rcoa.ac.uk
www.rcoa.ac.uk/events

JANUARY

› 10-13 JANUARY 2017
Primary FRCA Masterclass
RCoA, London
£305

› 16-20 JANUARY 2017
Final FRCA Revision Course
RCoA, London
£395

› 31 JANUARY 2017
Developing Perioperative Medicine across the UK
RCoA, London
BY INVITATION ONLY

FEBRUARY

› 6 FEBRUARY 2017
FPM Acute Pain Study Day
RCoA, London
£175 (£140 for RCoA registered trainees)

› 8 FEBRUARY 2017
Updates in Anaesthesia, Critical Care and Pain Management
RCoA, London
£490

› 20 FEBRUARY 2017
CPD Study Day: Update in Obstetric Anaesthesia
RCoA, London
£200 (£150 for RCoA registered trainees)

MARCH

› 1-2 MARCH 2017
Introduction to Leadership and Management: The Essentials
Novotel Hotel, Sheffield
£395

› 2 MARCH 2017
First Consultant Job – What You Need To Know
RCoA, London
£150

› 3 MARCH 2017
FPM Exam Tutorial
RCoA, London
£95

› 3 MARCH 2017
Joint RCoA and RCSEd Meeting:
Prehabilitation and Perioperative Care
Royal College of Surgeons, Edinburgh
£200 (£150 for RCoA registered trainees)
› 3 MARCH 2017
After the Final FRCA – Making the Most of Training Years 5 to 7
RCoA, London
£150

› 8-9 MARCH 2017
Anniversary Meeting: Landmarks in UK Anaesthesia
The Mermaid Conference Centre, London
£395 (£295 for RCoA registered trainees)

› 16 MARCH 2017
Leadership and Management: Leading and Managing Change; Success with Service Development
RCoA, London
£220

› 20 MARCH 2017
Tracheostomy Masterclass
RCoA, London
£240 (£180 for RCoA registered trainees)

› 23 MARCH 2017
Regional Advisors Meeting
RCoA, London
BY INVITATION ONLY

› 24 MARCH 2017
BJA/NIAA Research Methodology Workshop
RCoA, London
£150

› 27 MARCH 2017
CPD Study Day: Anaesthesia for Major Abdominal Surgery
RCoA, London
£200 (£150 for RCoA registered trainees)

› 30 MARCH 2017
Joint RCoA & RSM Meeting: Anaesthesia and Surgery: The Interface
RSM, London
For more information visit www.rsm.ac.uk/events

› 27-28 APRIL 2017
UK Training in Emergency Airway Management (TEAM) Course
Wrexham Maelor Hospital
£450

‡ APRIL

› 5 APRIL 2017
Airway Workshop
Hilton Brighton Metropole
£240 (£180 for RCoA registered trainees)

› 24 APRIL 2017
Safe Anaesthesia Seminar 2017
RCoA, London
£200 (£150 for RCoA registered trainees)

› 26 APRIL 2017
Quality Improvement and Patient Safety: Improvement Science in Anaesthesia Training
RCoA, London
£150

‡ MAY

› 3 MAY 2017
CPD Study Day: Bombs, Blasts and Other Disasters
RCoA, London
£200 (£150 for RCoA registered trainees)

› 4 MAY 2017
Airway Management: Training the Trainer
RCoA, London
£240 (£180 for RCoA registered trainees)

› 13-14 JUNE 2017
Summer Symposium
The Waterfront Hall, Belfast
£395 (£295 for RCoA registered trainees)

› 15-16 JUNE 2017
College Tutors Meeting
The Waterfront Hall, Belfast
Report of a meeting of Council

At a meeting of Council held on Wednesday, 19 October 2016, the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

**Regional Advisers**
There were no appointments.

**Deputy Regional Advisers**
There were no appointments.

**College Tutors**

**North West**
Dr C H Doherty [Royal Manchester Children's Hospital] in succession to Dr D P Fines
*Dr M J R Letheren [Lancashire Teaching Hospitals NHS Trust]

**West of Scotland**
*Dr N M Crutchley [Forth Valley Royal Hospital]

**KSS**
Dr L Campbell [Brighton Sussex University Hospital] in succession to Dr S Hardy
Dr K Solan [Brighton Sussex University Hospital] in succession to Dr S Sudan

**Leicester & South Trent**
*Dr A A Kelkar [Leicester General Hospital]

**Wales**
Dr H Reddy [Wrexham Maelor Hospital] in succession to Dr V Madhavan

**Head of Schools**
Dr Simon Mercer succeeded Dr Ann Holden as Associate Head of School for HEE North West School of Anaesthesia.

**Certificate of Completion of Training**
Council noted recommendations made to the GMC for approval, that CCTs/Certificate of Eligibility for Specialist Registration (Combined Programme) [CESR (CP)] be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia.

**October**

**Anglia**
Dr Najwan Abu Al-Saad

**KSS**
Dr Kieran Hills

**London**
North Central
Dr Abigail Whiteman
Dr Savita Kale
Dr Nipa Rahman
Dr Sarah Jones

**Barts and the London**
Dr Mevan Gooneratne

**South East**
Dr Emma Sans Solachi
Dr Sebastian Baxter
Dr Thivanka Wimalaratne

**St George’s**
Dr Manprit Waraich

**Northern Ireland**
Dr Rebecca Barr

**North West**
Dr Mark Anders
Dr Robert Loveridge

**Severn**
Dr Richard Edwards

**Wales**
Dr Mohammed Junaidu

**Stoke**
Dr Jessica Goude
Dr Isiaka Olowosale

**Birmingham**
Dr Mohammed Sajad

At a meeting of Council held on Wednesday, 16 November 2016, the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

**Regional Advisers**
There are no appointments or re-appointments this month.

**Deputy Regional Advisers**
There are no appointments or re-appointments this month.

**College Tutors**

**Anglia**
Dr E Schulenburg [Addenbrookes Hospital] in succession to Dr A V Patil
Dr C C Burt [Papworth Hospital] in succession to Dr K P Valchanov

**East Yorkshire**
Dr M S Achawal [Hull Royal Infirmary] in succession to Dr L Vestarkis

**North Thames Central**
Dr S Setty [Barnet Hospital] in succession to Dr M Chakravarti-Chattopadhyay
*Dr A Kambli [Lister Hospital]

Dr C Ferguson Acting Tutor [Royal National Throat, Nose and Ear Hospital] covering for Dr P O Suaris
Dr C Kidel Acting Tutor (Royal Free Hospital) covering for Dr T Jones

North Thames East
Dr N Watt (Newham University Hospital) in succession to Dr T Kundishora

Mersey
Dr J Crooke (Southport and Ormskirk NHS Trust) in succession to Dr T Kundishora

North Thames East
Dr N Watt (Newham University Hospital) in succession to Dr T Kundishora

Mersey
Dr J Crooke (Southport and Ormskirk NHS Trust) in succession to Dr T Kundishora

Wales
Dr H Maghur (University Hospital of Wales) in succession to Dr M Sandby Thomas

Head of Schools
There were no appointments or re-appointments this month.

Certificate of Completion of Training
Council noted recommendations made to the GMC for approval, that CCTs/ Certificate of Eligibility for Specialist Registration (Combined Programme) [CESR (CP)] be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia.

November
Leicester
Dr Sameer Hanna-Jumma
Dr Martin Minich
Dr Angela Green

Nottingham
Dr Irfan Mansur

North Central
Dr Renuka Arumainathan
Dr Selina Patel
Dr Seetal Snoek

Barts and the London
Dr Omar Hussain
Dr Matthew Hamilton
Dr Jerry Lim

South East
Dr Andrew Pool
Dr Rokin Mistry

Northern Ireland
Dr Paul McMackin

Northern
Dr Ravikiran Ramanujapuram
Anandampillai
Dr Kavitha Manoharan

North West
Dr Wan Khoo
Dr Arvinder Singh
Dr Kate Webster

South East Scotland
Dr Catherine Collinson

West of Scotland
Dr Catherine Vass
Dr Vanessa Vallance

South West Peninsula
Dr Danielle Franklin
Dr Katharine Stenlake
Dr Catharina Hoyer

Severn
Dr Janine Talbot
Dr Andrew Bartlett

Wales
Dr David West
Dr Vazira Moosajee
Dr Ceri-Ann Lynch
Dr Jenna Stevens

Wessex
Dr James Keegan
Dr Davina Watson
Dr Anamika Sehgal

Yorkshire and Humber
Dr Zoe Harclerode
Consultations

The following is a list of consultations which the RCoA has responded to in the last two months:

<table>
<thead>
<tr>
<th>Originator</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>Draft care of dying adults in the last days of life quality standard</td>
</tr>
<tr>
<td>NHS Improvement</td>
<td>Review of Never Events Policy and Framework</td>
</tr>
<tr>
<td>GMC</td>
<td>Standards for postgraduate curricula and regulated credentials</td>
</tr>
<tr>
<td>NHS Improvement</td>
<td>National tariff payment system 2017/18 to 2018/19 - Creating incentives in outpatients followups</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Providing a 'safe space' in healthcare safety investigations</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence/NHS England</td>
<td>Consultation on changes to the Technology Appraisals and Highly Specialised Technologies programmes</td>
</tr>
</tbody>
</table>
| NHS England                                     | Commissioning Policies: Funding of Treatment outside of Clinical Commissioning Policy or Mandated NICE Guidance:  
A. In-year service development  
B. Individual Funding Requests  
C. Funding for experimental and unproven treatments  
D. Continuing funding after clinical trials |
| Department of Health                            | Work, health and disability: improving lives                                 |

Appointment of Fellows to consultant and similar posts

The College congratulates the following Fellows on their consultant appointments:

- **Dr E Allison**  
  Sheffield Children's Hospital

- **Dr C Collinson**  
  Royal Infirmary of Edinburgh

- **Dr V Eli**  
  Princess Royal Hospital, Telford

- **Dr M Georghiou**  
  West Hertfordshire NHS Trust

- **Dr A Green**  
  Royal Derby Hospital

- **Dr H J C King**  
  Brighton & Sussex University Hospitals NHS Trust

- **Dr A Miraj**  
  Burton Hospitals NHS Trust

- **Dr R Natarajam**  
  Warwick Hospital

- **Dr N Rao**  
  University Hospital of North Midlands

- **Dr S Singh**  
  Colchester General Hospital

- **Dr J Talbot**  
  Royal United Hospital Bath NHS Trust

- **Dr L Terry**  
  Chesterfield Royal Infirmary

- **Dr R Wadsworth**  
  Sheffield Teaching Hospitals

- **Dr V L Williams**  
  Mid Cheshire Hospitals NHS Trust

- **Dr A Whiteman**  
  University College Hospital

- **Dr V Vallance**  
  Hairmyres Hospital
Deaths

With regret, we record the death of those listed below.

Dr Barbara W Adams, Glasgow
Dr Christopher P Allen, USA
Dr George J C Brittain, Castletown
Dr H R I Khali, England
Professor James Parkhouse, England
Dr Balendra Wyramutto Rasiah, New Zealand
Dr Jane Risdall, England
Dr Douglas Stewart Robbie, England
Nigel Salmon, England
Dr David Zuck, England

Please submit obituaries of no more than 500 words, with a photo if desired, of Fellows, Members or Trainees to: website@rcoa.ac.uk.

All obituaries received will be published on the College website (www.rcoa.ac.uk/obituaries).

Appointment of Members, Associate Members and Associate Fellows

Associate Fellows:
Dr Shyam Sundar Thota
Dr Kim Alexander Nuyen
Dr D Zioga
Dr Federico Mentegazzi
Dr Ruth Neary
Dr Nuria Masip Rodrigue

Member:
Dr Deepa Thampi

Associate Members:
Dr Faris Abdallah
Dr Catalina Bianca Samoila
Dr Aaron Abel Jeremy D’Sa
Dr I Souleimanova

Affiliate – Physicians’ Assistant:
Ms Lindsay Rutherford

GPAS EDITOR

The Royal College of Anaesthetists (RCoA) wishes to appoint an Editor for its Guidelines for the Provision of Anaesthetic Services (GPAS) document.

The postholder will be expected to provide senior clinical and academic support to GPAS, as well as fulfilling a key role in authoring, editing and copy-editing GPAS chapters in cooperation with chapter authors.

The postholder will report directly to the Chairman of the Professional Standards Committee and will be required to lead the integration of GPAS with other areas of the RCoA’s work to set, measure and promote standards of good anaesthetic practice.

The position is a fixed-term post of three years, subject to an annual performance review. It is supported by the cost of two periods of professional activity per week, backfilled to the postholder’s employing trust or board, to enable the successful candidate to dedicate a minimum of 8 hours per week to the role.

Further information about GPAS, the job description, person specification and how to apply is available via www.rcoa.ac.uk/job-vacancies

The closing date for applications is 5pm on 31 January 2017.
Shortlisted candidates will be contacted and interviews will take place on 7 February 2017.

CLINICAL QUALITY ADVISER

The Royal College of Anaesthetists (RCoA) will have a vacancy for the position of Clinical Quality Adviser from April 2017.

Responsibilities include responding to clinical enquiries received by the Clinical Quality and Research Directorate and the provision of up to date medical and anaesthesia advice to College Council, committees and individual anaesthetists as and when required.

The successful candidate will also provide day to day support to the RCoA’s Invited Review programme.

The position is a fixed-term post of three years, renewable annually subject to performance. The post is supported by the cost of two periods of professional activity, backfilled to the postholder’s employing trust or board to enable the successful candidate to dedicate a minimum of 8 hours per week to the role. It is expected that the post holder would attend and work at the RCoA for one session per week. Specific hours and days of working are flexible and should reflect the ongoing needs of the post.

Further details including information about the RCoA Clinical Quality and Research Directorate, the job description, person specification and how to apply are available via www.rcoa.ac.uk/job-vacancies

The closing date for applications is 5pm on 28 February 2017.
Shortlisted candidates will be contacted and interviews will take place on 14 March 2017.
RCoA venue and facilities hire

To hire our facilities or for a tour around the venue simply call the room bookings hotline on: 020 7092 1510, or email us at: roombookings@rcoa.ac.uk.

For further information, and to download our brochure please visit our website at www.rcoa.ac.uk/venue
16th Peri-Operative CPET Course
Montague Hotel, London
17th & 18th May 2017
Cardiopulmonary Exercise Testing For Pre-operative Assessment Course
■ Only 40 delegate places per course
■ Faculty to Delegate ratio 1:4
■ Lectures, small group tutorials and workshops
■ Underlying Physiology
■ Test Interpretation
■ Respiratory and Cardiac abnormalities
■ Testing Practicalities
■ Setting up a new service

Annual London Peri-Operative Medicine Congress
EBPOM 2017
Institute of Education, London
4th, 5th & 6th July 2017
Call for Abstracts - Deadline 12th April 2017
3 Days of Lectures, Breakouts and Workshops
‘Early Bird’ Registration to 31.03.2017
To submit an abstract visit: www.ebpom.org/abstracts

European Practicum of Cardiopulmonary Exercise Testing
Balmer Lawn New Forest Hotel
7th – 9th November 2017
■ 3 Days of Lectures, Breakouts, Workshops.
■ Renowned international faculty featuring:
  Paul Older
  Melbourne, Australia
■ Research Presentations Prize

19th Current Controversies in Anaesthesia & Peri-Operative Medicine
Dingle, Co. Kerry, Ireland
4th – 8th October 2017
Call for Abstracts
£1000 in Prizes. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 12th July 2017. Trainees with abstract accepted for poster presentation are entitled to a £50 discount on registration and an additional £50 discount if also accepted for UCL oral presentation. All presenters, both poster & oral, must register for the conference to present their work.

Guest Speaker: Paul Myles
Melbourne, Australia
Vacancy: Chair of the National Institute of Academic Anaesthesia Research Council

Applications are invited for the role of Chair of the National Institute of Academic Anaesthesia (NIAA) Research Council.

The NIAA is a partnership body, made up of four founding partners, the Royal College of Anaesthetists (RCoA), the Association of Anaesthetists of Great Britain & Ireland (AAGBI), the British Journal of Anaesthesia and Anaesthesia and funding partner organisations (specialist societies).

The postholder will be expected to provide senior leadership and academic support to the NIAA Research Council. He/she will develop and deliver the research strategy of the NIAA as set out by the NIAA Board and oversee the award of grant funding. Our funding portfolio to date is approximately £6.6 million in eight full years of activity.

The postholder will also be required to build strategic relationships with funding partners to support research in national priority areas and support the ‘research aware’, ‘research ready’ and ‘research experienced’ through the development and promotion of training opportunities.

The position is a fixed-term post of three years. There is no remuneration for the role.

Further information about the NIAA and the role is available on the NIAA website: www.niaa.org.uk

The closing date for applications is 5.00 pm on 24 March 2017 and interviews will take place in April 2017.
SMART® ANAESTHESIA COURSE
(STRUCTURED MANAGEMENT AIRWAY RESPONSE TEAM)
SUPPORTED BY DIFFICULT AIRWAY SOCIETY (DAS) UK

18 May 2017 to 19 October 2017
at University Hospital, Coventry

SMART a one-day course for anaesthetists-ODP teams is a unique blend of expert teachings and insights based on well-backed scientific evidence that can help you recognise, prevent and overcome human limitations and fallibilities. It involves interactive team training, simulation, airway-technical skills, Error Avoidance strategy, Human Factors in crisis management and Practical briefing and debriefing skills.

Course fee: Consultant Anaesthetist: £150
SAS/Trainee Anaesthetist: £120
One ODP/ Nurse can accompany free as a team from same hospital.
Individual anaesthetists and theatre team members are welcome to apply (ODP/ Nurse Course fee £75)

PLACES ARE LIMITED SO PLEASE APPLY EARLY
For further details please contact Rachel on 024 7696 8722
E-mail: courses@mededcoventry.com
or visit www.mededcoventry.com

COVENTRY AIRWAY MANAGEMENT COURSE
8 March 2017 to 4 October 2017
at University Hospital, Coventry

- ORSIM Bronchoscopy Simulator
- Oral & Nasal Fibreoptic Intubation
- Fibreoptic Intubation through LMA/Igel
- Videolaryngoscopes
- Lung Isolation Techniques
- Ultrasound Imaging of Airway
- Front of Neck Access
- Difficult Airway Scenarios
- Awake Fibreoptic Intubation
- Extubation

PLACES ARE LIMITED SO PLEASE APPLY EARLY
Registration fee: £95
includes refreshments and lunch
For further details please contact Rachel on 024 7696 8722 or e-mail: courses@mededcoventry.com or visit www.mededcoventry.com

COVENTRY PRIMARY FRCA MCQ/SBA COURSE
24–26 January 2017 to 19 October 2017
25–27 July 2017 to 19 October 2017

- A three-day course with intensive MCQ/SBA practice in physiology, pharmacology, physics and clinical measurement under strict exam conditions
- A three-hour test paper on day three and candidates will receive feedback on their daily performance
- Over 350 MCQs and 180 SBAs will be analysed
- Access to pre-course material including past MCQs
- Access to all course presentations and further MCQs on the web
- Interactive discussion of Single Best Answer questions using Turning Point technology
- Pre-course MCQ practice and feedback starts 6 weeks prior to the course

PLACES ARE LIMITED SO PLEASE APPLY EARLY
Registration fee: £290 includes a copy of SBA – Basic Sciences book, breakfast, lunch and refreshments
For further details please contact: courses@mededcoventry.com or telephone 024 7696 8722

FINAL FRCA MCQ/SQA COURSE
14–16 February 2017 to 17–19 July 2017
at University Hospital, Coventry

- MCQ practice in medicine, surgery, clinical measurement, intensive care medicine, anaesthesia and pain management under strict exam conditions. SBA practice in clinical anaesthesia, pain and intensive care medicine.
- SAQ practice in intensive care medicine, neuroanaesthesia, chronic pain, cardiac anaesthesia, paediatric anaesthesia and trauma.
- Mock exam in SAQ and MCQ/SBA.
- Interactive discussion of Single Best Answer questions using Turning Point technology.
- Pre-course SAQ practice and feedback starts two months prior to the course.

Registration fee: £300
Includes a copy of SOE in clinical anaesthesia book, breakfast, lunch and refreshments
For further details please contact courses@mededcoventry.com or telephone 024 7696 8722
www.anaesthetics.uk.com or www.mededcoventry.com
THE MSA SAQ WRITERS CLUB

The Writers Club has seen more than 500+ trainees through the SAQ Papers with a successful Pass Rate for those who have kept to the necessary disciplines. But many trainees apply far too close to the examination to derive anything like the full benefit from Membership. That Full Benefit includes Free Admission to the SAQ Weekend Courses, the Acquisition of a large and useful Collection of Answer Sheets and a Valuable Motivation towards Sustained Revision.

Membership fee: a single payment of £400

Members are entitled to all benefits until successful in the SAQ Paper

Attendance to the SAQ Weekend Course – free of charge

Writers Club Motto: ‘Within the Discipline, Lies the Reward’

Candidates are urged to join between now and April for the Autumn 2017 Examination to reap maximum benefit

Enquiries to: writersclub.msa@gmail.com

Courses for the Royal College of Anaesthetists Examinations

<table>
<thead>
<tr>
<th>Courses</th>
<th>Dates 2016/2017</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary SBA/MCQ</td>
<td>27 Jan–2 Feb</td>
<td>21–27 July</td>
</tr>
<tr>
<td>Primary OSCE Weekend</td>
<td>1–18 December</td>
<td>2–23 April</td>
</tr>
<tr>
<td>Primary Viva Weekend</td>
<td>6–8 January</td>
<td>28–30 April</td>
</tr>
<tr>
<td>Primary OSCE/Orals</td>
<td>13–20 January</td>
<td>5–12 May</td>
</tr>
<tr>
<td>Final Written ‘Booker’</td>
<td>12–16 February</td>
<td>August 2017</td>
</tr>
<tr>
<td>Final SAQ Weekend</td>
<td>17–19 February</td>
<td>August 2017</td>
</tr>
<tr>
<td>Final SBA/MCQ</td>
<td>20–26 February</td>
<td>August 2017</td>
</tr>
<tr>
<td>Final Viva Revision</td>
<td>13–18 May</td>
<td>November 2017</td>
</tr>
<tr>
<td>Final Viva Weekend</td>
<td>9–11 June</td>
<td>November 2017</td>
</tr>
</tbody>
</table>

“After 18 months in the WC I’d like to withdraw - I’ve finally passed the written on my 4th attempt. I have to thank the MSA for contributing to my eventual success!

Since joining WC after my first unsuccessful attempt I have passed the SAQ component each time, improving my marks on each sitting.

I had struggled with the SBA component of the MCQ paper, scoring only 16/30 on my last sitting and failing by only a few marks, however on this occasion I scored 26/30! I can only put this down to my recent attendance at the MSA SBA/MCQ Course which really helped me consider how I approached this component of the exam. I will be recommending to all of my colleagues sitting the exam to spend their money attending your courses, rather than to pay for re-sits!

I look forward to seeing you all in November for some SOE practice.” – Final Written Candidate, September 2016

To see details of all of our courses please visit: www.msoa.org.uk or contact us at: enquiries@msoa.org.uk
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