Sustainability and Transformation Plans: the future of the NHS?

How might the intensive care medicine consultant of the future make it to retirement at 72?

Reflections on military anaesthesia over the last 25 years

MARCH 2017

Bulletin
The magazine for members of the Royal College of Anaesthetists

www.rcoa.ac.uk
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Welcome to the March 2017 Bulletin. I am writing this in January so I am looking at a full unit (ITU), an empty fitbit, a growing deficit, Brexit and Trumpit and life is... not exactly as I might have hoped. My mood was not helped by some of the articles in this Bulletin.

Our President gives us a crisp summary of the next major restructuring of the NHS: ‘Sustainability and Transformation Plans’ or ‘STPs’ (a three-letter acronym you will be hearing a lot of this year). STPs are five-year blueprints covering all aspects of NHS care and spending, so brace yourself.

I asked Professor Julian Bion, founding Dean of the Faculty of Intensive Care Medicine, for insights on working until I’m 72. He didn’t exactly cheer me up and in fact managed to make me feel guilty about my self-interest, when I read that: ‘Today’s 35-year-olds may need to work until the age of 81’. He does, however, offer glimmers of hope that will need immediate attention if we are going to make the long-haul.

As I write this President Trump has closed the USA border to many and this is being challenged in the courts. I am hopeful that, by the time you read this in March, common sense will have prevailed. I am encouraged by the article on ‘cross-cultural communication’ by Drs Stojiljkovic and Yilmaz from Chicago, USA, which concludes that ‘effective communication styles and skills are capable of transforming conflict into collaboration’.

The young always offer hope. Dr Anne-Marie Bougeard (Torbay), the RCoA Perioperative Medicine Fellow, updates us on the new strategy for addressing key challenges in the care of our surgical population, and updates us on the mass engagement from College Fellows. Dr Danny Wong, NIAA Health Services Research Centre Fellow, primes us for the imminent second Sprint National Anaesthesia Project (SNAP-2).

Surgeon Captain Andrew Burgess, Former Defence Consultant Advisor in Anaesthesia; Medical Director, Bastion; and Military Clinical Director Defence Medical Group SW (Plymouth), in his article on 25 years of military anaesthesia, gives my current concerns perspective when he reminds us that: ‘By 1992, the Cold War had finished, the first Gulf War had only just ended, Irish ‘Troubles’ were ongoing and the Bosnian war was just starting. Anaesthetic commitments persisted, although a different approach to manning and training existed then, with less operational theatre-specific training, and predominantly junior anaesthetists being tasked. This changed dramatically over the next few years...for the better.’
It is clear to everyone working in UK healthcare that the NHS is under unprecedented pressure. Spiralling demand, fuelled by the needs of an increasingly ageing population but without a matching increase in health and social care funding, has led to the current crisis. So how is the NHS going to cope with the greatest challenge in its history? In England, the response has been the formulation of Sustainability and Transformation Plans (STPs), five-year blueprints covering all aspects of NHS care and spending. This short overview will outline what STPs are and their implications for our specialty in England.

What are STPs?
In early 2016, NHS England published a map of 44 STP footprints (http://bit.ly/1Uzs8qk) — geographical areas with an average population of 1.2 million. In each area, health and social care organisations were mandated to draw up local plans considering three key issues: improving quality and developing new models of care; improving health and well-being; and improving efficiency of services. ‘Improving efficiency...’ is a euphemism for cost saving, as it is expected that these ambitious plans will be delivered whilst meeting the challenge of saving £22 billion from the NHS England budget by 2021, as outlined in the ‘Five Year Forward View’ (http://bit.ly/1ivuwY5).

An important overarching principle is that there should be better integration with primary care as well as with social care and other local authority services. This is essential to meet the needs of, in particular, frail elderly patients who too often, although medically fit for discharge, cannot return home due to an inadequate support package — so called ‘delayed transfers of care’.

All of the STPs have now been published. Disappointingly, there has been a paucity of engagement with clinicians, healthcare professionals in general or patients, in the creation of STPs.
of the plans. However, there will now be a period of consultation that will undoubtedly be controversial, because many of the plans recommend radical solutions, including reconfiguration or even closure of some services in order to meet the remit set by NHS England. The plans will need to be stress-tested to ensure that they are credible, and that the serious changes they propose can be delivered with the levels of funding and the timescale available. Apart from achieving stakeholder buy-in, this will be essential, because only the most well-constructed plans will be eligible to receive the limited extra transformation funding available to smooth their implementation.

So what is the College’s view of STPs?

The College welcomes any initiative that improves patient care and outcomes, and actively seeks to get involved in supporting that aim. However, we strongly believe that any decisions made around STPs must have the highest standards of patient care – and not financial savings – as their primary focus. In addition, with such a complex framework of health and social care footprints, it will be vital for neighbouring STPs to work in a co-ordinated way, so that decisions taken by one STP area do not negatively affect a neighbouring STP area. The Clinical Senates [link to LS&S2] set up following the implementation of the Health and Social Care Act 2012 are the suggested source of independent, strategic advice and guidance to commissioners and other stakeholders, to assist them in making the best decisions about healthcare for the populations they represent. Each senate should, in theory, have anaesthesia and/or intensive care representation to voice the concerns of our specialties. Clearly grass-roots clinicians must be fully involved in the formation and finalisation of the STPs, and there must be appropriate consultation with patients and patient groups. Anaesthesia, critical care and pain medicine services are specialties sometimes overlooked in strategic planning, and all STPs must include a proper assessment of their impact on staffing requirements in these specialties. Besides our traditional perioperative care role, these assessments must include (but not be limited to) impact on services for trauma management, resuscitation, patient retrieval, interventional radiology, procedural sedation, advanced pain relief and the availability of intensive/high dependency care.

Reconfiguration or closure of services is highly likely to have consequences on the capacity to train the next generation of anaesthetists, and for the existing trained workforce’s ability to maintain their skills. The College is unequivocal that the quality and scope of training and life-long learning for clinicians for the benefit of patients must not be compromised, and this must be considered in all STP consultations. STPs may include plans to develop alternative workforce models such as the further development of medical associate practitioners, including Physicians Assistants in Anaesthesia (PAs). The RCoA broadly supports plans to increase the training and employment of non-medically-qualified clinical care practitioners in order to augment clinical service delivery, but this workforce must be adequately resourced, including a well-defined training structure underpinned by statutory regulation.

With such a large number of proposals, the RCoA will not be able to provide a response on every individual STP. However, when major issues and concerns are raised that directly impact on the delivery of anaesthetic services and related disciplines, the College can offer comment and/or an invited Review [link to LS&S2]. We are fortunate to have mature regional networks, led by our Regional Advisors, which will provide a point of contact for STPs for specialty-related issues.

Finally, the College believes that our initiatives in perioperative medicine, [link to LS&S2] particularly those designed to improve patient care, shorten hospital admissions and enhance efficiency in the provision of elective surgery, align perfectly with the key STP principles. We have made these representations to the senior leadership in NHS England and would encourage our members to highlight local perioperative medicine initiatives in STP consultations.

Final thoughts

STPs are going to have far-reaching implications for the future of health and social care services in England. As a specialty that is fundamental to the delivery of secondary and tertiary care, the impact on anaesthesia and our related disciplines is likely to be very significant. We are raising these concerns at the highest levels of NHS England and the RCoA’s Council, and I will continue to do all that I can to represent the national view. I encourage all our fellows and members to scrutinise their local STP and engage in the local consultation process, so that the views of anaesthesia, critical care and pain medicine are clearly heard. If you are involved in a consultation around your local STP please keep the College informed by letting the RCoAs Regional Representatives Support Co-ordinator, Karen Morris, know: kmorris@rcoa.ac.uk.

As always, if you have any comments on any of the issues discussed in this article or you would like to express your views on any other matters, I would like to hear from you. Please contact me via presidentnews@rcoa.ac.uk.

THE COLLEGE WELCOMES ANY INITIATIVE THAT IMPROVES PATIENT CARE AND OUTCOMES, AND ACTIVELY SEeks TO GET INVOLVED IN SUPPORTING THAT AIM
Clinical Quality update

2016 was a productive year for the College’s Clinical Quality team, particularly regarding the continued success of the Anaesthesia Clinical Services Accreditation (ACSA) scheme. With 85 UK anaesthetic departments now ACSA registered and 17 additional department visits booked for 2017, the uptake of the College’s ACSA standards is extremely encouraging. Early 2017 will see the updated ACSA standards published if you would like to find out more please contact:

ACSA@RCOA.AC.UK
WWW.RCOA.AC.UK/ACSA

The College’s Invited Review service has undergone an internal evaluation of its processes and structure. Further details of the revised practice can be requested by contacting:

ART@RCOA.AC.UK
WWW.RCOA.AC.UK/ART

The Guidelines for the Provision of Anaesthetic Services (GPAS) chapters continue to undergo NICE accreditation. In 2017 the following chapters are due to receive their NICE accreditation: Anaesthesia services for intra-operative care; Obstetric anaesthesia services; Paediatric anaesthesia services; Ophthalmic anaesthesia services; and Burns and Plastics anaesthesia services.

For more information on these chapters, or on NICE accreditation, please contact:

GPAS@RCOA.AC.UK
WWW.RCOA.AC.UK/GPAS

News in brief

HRH The Princess Royal to attend RCoA’s Anniversary Meeting

We are delighted to announce that RCoA’s Patron, Her Royal Highness The Princess Royal, will attend our Anniversary Meeting on 8 March 2017 as guest of honour. The Princess Royal will open the meeting – the flagship event of our 25th Anniversary celebrations – which will focus on Landmarks in Anaesthesia which have occurred during the past 25 years. The Princess Royal will also present the inaugural RCoA/National Institute for Health Research Clinical Research Network (NIHR-CRN) awards. These two awards aim to recognise the outstanding contributions of NHS clinicians to clinical research, particularly in relation to NIHR-CRN Portfolio research studies. There will be two awards in this category, for consultants and trainees.

The two-day programme for the Anniversary Meeting, also includes a variety of world-renowned national and international speakers who have played a major role in the development of the specialty or contributed to the work of the College. Speakers include Professors Lord Darzi, Kate Leslie, Simon Howell, Carol Peden, Jennie Hunter plus many more.

Delegate places for the Anniversary Meeting on 8 and 9 March 2017 are still available. The meeting takes place at the Mermaid Conference Centre in London. To register for this event, please visit: WWW.RCOA.AC.UK/ANNIVERSARY

FRCA Examinations update

Congratulations to members who’ve passed exams in the last few months.

The Final FRCA SOE December pass rate was 68% which directly compares to other sittings, with the mean for the last four exams being 67%. A total of 321 candidates sat the January OSCE/SOE, with a pass rate of 51%. The Primary MCQ took place on 28 February, while the Final Written sits on 7 March. The release of result dates can be found on the (http://bit.ly/2qyPfNm).

Work on changing the Final SAQ to a Constructed Response Question (CRQ) exam is now well underway. The RCoA examiner board is focusing on adding CRQs to the bank with two examiner writing days planned for April and May this year. The new CRQ exam will consist of eight Long and eight Short questions over three hours. The first CRQ exam is expected to take place in September 2019.

Work is also taking place on the change to the Final FRCA Structure Oral Examination (SOE). The timetable will be amended so that candidates interact with six different examiners. The long case element will be shortened so that the curriculum can be more broadly sampled and Clinical Science will be tested in both parts of the exam rather than just one. The expected date of this change is December 2018.

RCoA member engagement

In the 2016–2021 strategic plan our President, Dr Liam Brennan, announced that the College will be making significant changes in the way we operate, interact with members and stakeholders, and how we communicate both internally and externally. This commitment to engagement can be seen in one of the College’s most recent recruitments to our permanent staff, Alice Dartnell (above), who started her role as the Member Engagement Manager in mid-January.

Alice said: ‘I am delighted to be here in this role. It is clear from the strategy and senior management that the College is unwavering in its commitment to supporting its members. I look forward to working with the staff across the different directorates to increase our opportunities for engagement with the profession and members.’

The College greatly values its membership and welcomes feedback from you which can help to further our aspirations and mission. Alice has pledged to engage with the recently developed Member Engagement Panel within her first few weeks, recognising the value of listening to the membership. If you would like to be involved in the Member Engagement Panel, please contact: engage@rcoa.ac.uk

The Checklist Effect with Lifebox and AAGBI

The RCoA is excited to host a special screening of The Checklist Effect: an extraordinary film for anyone who’s had surgery or might need it one day [https://vimeo.com/181653186].

Inspired by surgeon and author Atul Gawande’s award-winning book The Checklist Manifesto, this film explores the challenges of delivering safe surgery on a global scale – and how a seemingly simple piece of paper can mean the difference between life and death.

Follow the camera across eight countries, from snowy Moldova to the wide steppes of Mongolia, into communities, families, and the lives at stake. Go behind the scenes of one of science’s most sacred spaces: the operating room.

The screening will take place on 25 April 2017 at the RCoA. A panel discussion and networking opportunity will follow the film. Instead of admission tickets, a donation of £20 made to Lifebox Foundation is suggested.

This inspirational film will be of interest to all, serving as an introduction and eye opener to individuals without a Global health background, and a reminder of the importance of striving for better health care to those with experience overseas. For more information and to book your place, please see: www.rcoa.ac.uk/global-partnership.
the meeting of Council on 14 December 2016, the proposals for the role were approved. Closely with current role holders, who have provided valuable input into shaping the final model of this important College role. At Over the past 12 months the College has undertaken a review of the role of the Regional Adviser. This has involved working Regional Advisers Anaesthesia (RAA) with Postgraduate Deans, employers and fellow anaesthetists on all matters relating to training, professional standards, education and continuing professional development. They are integral to the functioning of the specialty and maintain regular liaison with, and report to, College officers and committees.

One Regional Adviser Anaesthesia (RAA) will represent each School, and it was agreed that the locality name of the School will be appended to the responsibility for mentoring. Support to attend an RAA meeting and clear lines of reporting and an on-going programme of work which includes an induction programme, support to attend an RAA meeting and clear lines of reporting and responsibility for mentoring.

To see a list of the bodies involved in the Perioperative Medicine Advisory Board visit the POM microsite: PEDIATRICMEDICINE@RCOA.AC.UK WWW.RCOA.AC.UK/PERIOPERATIVEMEDICINE

Regional Advisers Anaesthesia (RAA)

Over the past 12 months the College has undertaken a review of the role of the Regional Adviser. This has involved working closely with current role holders, who have provided valuable input into shaping the final model of this important College role. At the meeting of Council on 14 December 2016, the proposals for the role were approved. The title of the role has been updated to reflect the wide-ranging nature of the position. Regional Advisers Anaesthesia are the College’s most senior regional/local representatives who work with Postgraduate Deans, employers and fellow anaesthetists on all matters relating to training, professional standards, education and continuing professional development. They are integral to the functioning of the specialty and maintain regular liaison with, and report to, College officers and committees.

One Regional Adviser Anaesthesia (RAA) will represent each School, and it was agreed that the locality name of the School will be appended to the term RAA, for example RAA Wessex or RAA Northern.

We are now working on implementing all of the changes via an on-going programme of work which includes an induction programme, support to attend an RAA meeting and clear lines of reporting and responsibility for mentoring.

Perioperative Medicine (POM)

RCOA believes that collaborative and efficient perioperative care is the route to effective and sustainable surgery. With many components of the perioperative medicine pathway already existing within the NHS, the College has produced a vision document, Perioperative Medicine: The Pathway to Better Surgical Care (http://bit.ly/2khY3zK) and has developed a film (http://bit.ly/2k1B0CQ) to illustrate what good perioperative care can look like.

The College is extremely pleased to now have over 160 Perioperative Medicine Local Leads based in hospitals across the UK. The first annual event for POM Leads was held at the College on Tuesday, 31 January and was a day of networking, best practice sharing and discussion around key focus areas in perioperative medicine. In 2017 we will be supporting similar events to be held locally – if you are interested in holding such an event please get in touch.

We will soon start producing case studies (http://bit.ly/2khY1F3) on POM best practice models, further elaborating on the examples we currently have displayed on the POM microsite. Keep an eye out for these over the coming months.

The Perioperative Quality Improvement Programme (www.niaa-hsr.org.uk/PCQ2) has now begun patient recruitment. Plymouth Derriford recruited the first patient on 13 December 2016, followed by (at the time of writing) Russells Hall, Birmingham Heartlands, Arrowe Park, York, Salford and the Royal Bolton. Congratulations to all involved. If your centre is not currently involved, contact your R&D department telling them you want to join this NIHR portfolio adopted study (CPMS ID 32256) or email pqip@rcoa.ac.uk for assistance.

The 2nd Sprint National Anaesthesia Project (SNAP-2) (www.niaa-hsr.org.uk/SNAP-2-EpiCCS) was piloted in January, with the main study running from Tuesday, 21 March 2017 for one week of patient recruitment. SNAP-2 will look at the epidemiology of critical care provision after surgery. As with SNAP-1, we want to get as close to 100% coverage of UK NHS Trusts as possible. SNAP-2 is also on the NIHR portfolio (CPMS ID 39913) meaning every patient for whom data is collected will count towards NIHR accruals targets, so do get involved.

Finally, the NELA team has launched a series of animations (http://bit.ly/2f9k8tj) on using audit data to drive local quality improvement. See if the techniques involved can be used in your Trust and let us know your outcomes.

Research and Quality Improvement

Work continues on numerous research projects under the auspices of the Health Services Research Centre (HSRC). More information about HSRC research can be found at: www.niaa-hsr.org.uk.

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News in brief

For the RCoA, 16 March 2017 is a significant date in our history as it marks 25 years since we gained our Royal Charter. We are proud to be running a number of events in March and throughout 2017 to commemorate the occasion; these include:

- Anniversary Meeting: Landmarks in UK Anaesthesia – 8–9 March
- Joint Meeting of the Manchester Medical Society, Section of Anaesthesia and Liverpool Society of Anaesthetists RCoA 25th Anniversary Meeting – 16 March
- Xtreme Everest: Taking Medicine from Mountainside to Bedside lecture by Professor Mike Grocott – 21 March
- RCoA Career Day – 22 March
- Joint RCoA and RSM Meeting: Anaesthesia and Surgery: the Interface – 30 March

The RCoA Trainer Award was launched in 2016 and we received nominations from all Schools of Anaesthesia. The winners of our inaugural Trainer Award are announced on page 50. The deadline for the medical student, foundation year and anaesthetists in training essay prizes is fast approaching on 3 April. We encourage you to get involved in the 25th Anniversary programme by supporting a “Meet the Expert” event or signing up to the “Inspiring the Future” scheme.

Visit our 25th Anniversary website for information on the above or contact us by email: WWW.RCOA.AC.UK/RCOA25 RCOA25@RCOA.AC.UK
Until 1908, retirement was either the privilege of the wealthy or the misfortune of the disabled: everyone else kept working. The first UK old-age-pension scheme paid men five shillings a week after age 70 when life expectancy was 47 years; it is now 84 for men, 86 for women. In response, the government plans to increase the state pension age to 67 by 2028; the Office for Budget Responsibility predicts an increase to 69 in the 2040s, and (in a return to the 1908 pension age) to 70 by early 2060. Today’s 35-year-olds may need to work until the age of 81.

Attitudes and approaches to retirement vary widely. Some surveys suggest that many people wish to continue to work after the age of 65 for positive reasons associated with employment and health. In the NHS by contrast, a crisis in morale resulting from workload, constant change and perceived unsympathetic management contributes to recruitment and retention problems. Substantial gaps in consultant rotas and the new junior doctors’ contract discourage recruitment and retention in specialties with arduous out-of-hours workloads.

How should we respond to these challenges to make the acute specialties family-friendly, creative and rewarding occupations for three-score years and ten? Over 30 years as a specialist in Intensive Care Medicine (ICM), I have observed remarkable improvements in patient care and outcomes; doctor-patient relationships are now more equal and negotiated, and less paternalistic and didactic. However, expectations and demands have increased, particularly in relation to targets and performance indicators, some of which bear little relationship to the quality of clinical practice. The medical workforce has become less engaged, collegiate, confident, and empowered, and more fragmented, contractual, and compartmentalised. We are paid more, and rewarded less. Doctors need to become more involved in health-system management, but this is not a one-way process: managers should be more visible in the clinical environment and their objectives better aligned with clinical priorities. The NHS staff survey shows that clinical staff feel unsupported by senior managers: perhaps comparable frustrations are expressed in the opposite direction. Trusts should actively encourage staff to attend their monthly public board meetings. Royal Colleges should look for synergies between physician and managerial training programmes.
DELIVERING HIGH-QUALITY CLINICAL CARE OVER MANY YEARS IS FACILITATED BY A SENSE OF MORAL WORTH ACHIEVED THROUGH CREATIVE ACTIVITIES AND CONSTRUCTIVE SELF-CRITICISM.

and fellowships in NHS England and the Faculty for Medical Leadership. Getting buy-in to the strategic development of healthcare should enhance retention and morale.

At a local level, building long-term relationships with our patients and relatives brings many benefits and can be mutually therapeutic. Patient groups are the norm for specialties with a large chronic disease component; but less common for acute specialties. Patients and relatives strongly support quality improvement, contribute to research, and remind us why we came to work each day. Value and respect enhance staff retention.

The way we behave towards each other is crucially influenced by our career choices and our own satisfaction with work. We can be positive or negative role models, supportive of colleagues or antipathetic. Social signals subtly influence who we choose as working partners for one-third of our lives, and how long we wish to continue a relationship. Mutual support and teamwork between doctors and nurses is visible expression of pastoral responsibility.

Intensive care selects those who like acuity and diversity of practice. However, there are times when this becomes too burdensome: we have all experienced distress at the death of a patient, an error in practice, too many admissions, distress at the death of a patient, an error in practice, too many admissions, and the intense workload that can make this become too burdensome. We have all experienced these complex issues.

References

Society for Education in Anaesthesia (SEA UK)

CROSS-CULTURAL COMMUNICATION: AN ESSENTIAL SKILL FOR PHYSICIANS

Dr Ljuba Stojiljkovic, Northwestern University Feinberg School of Medicine, Chicago, USA

Dr Meltem Yilmaz, Northwestern University Feinberg School of Medicine, Chicago, USA

Culture could be defined as a pattern of symbols, meanings and rules that are shared among people with a common cultural background. It is a ‘software of the mind,’ that we get programmed with early in childhood.1 The ‘Cultural Software’ allows for smooth and effective interpersonal and within-group interaction and communication.

Most of these culturally shaped patterns are invisible. Visible culture characteristics like language, fashion, music, and artifacts are just the tip of the iceberg.

Communication is shaped by cultural upbringings. The relationship between culture and communication is complex and dynamic, as cultural symbolic patterns are accomplished and reinforced via communication. Styles of communication styles are deep under the surface; they are not easily accessible, and even more difficult to learn, especially by people who are newcomers to the group.

Dr Meltem Yilmaz, Northwestern University Feinberg School of Medicine, Chicago, USA

Dr Ljuba Stojiljkovic, Northwestern University Feinberg School of Medicine, Chicago, USA
Colleges recognised the importance of communication skills. However, in 1999, rapid changes in medical education and medical practice have overtaken medical school curricula and training, the communication skills will be necessary prerequisites for medical residents.1,2 Since 1998, the Accreditation Council for Graduate Medical Education (US) has included Communication Competence as one of the 8 core competencies.3 Based on these reports, the governing bodies for continued accreditation adopted Communication Competence requirements for medical residents.3,4

Often these non-verbal signals may lead to stereotyping of other cultures. Historically in medical education, communication skills were taught with the perspective that, with the provision of medical knowledge and training, the communication skills will follow. Medical school curricula and residency programs emphasized medical sciences, and little attention was given to communication skills. However, in 1999, the American Association of Medical Colleges recognised the importance of communication in medical education.5 In the Institute of Medicine Report ‘Unequal Treatment’ it was recognised that a failure to recognise cultural beliefs and behaviours leads to poor health outcomes, and dissatisfaction and non-adherence to treatment by patients.6 Based on these reports, the governing bodies for continued accreditation adopted Communication Competence requirements for medical residents.2,5

The first of these, ‘Taking revalidation forward – Improving the process of relicensing for doctors’ (http://bit.ly/2wFuGyS), was written by Sir Keith Pearson, Independent Chair of the GMC’s Revalidation Advisory Board, and published on 13 January 2017. This report was developed following consultation with a variety of stakeholders including the medical Royal Colleges and Faculties, the British Medical Association, NHS Employers, and a number of patient groups.

In summary, Sir Keith felt that revalidation was progressing as expected, and he commented: ‘During my review I heard many times that revalidation has benefits for doctors in reassuring them about the safety and the quality of their practice’. The report also mentioned how one of the benefits of delivering revalidation has been to embed the system of annual appraisals for doctors. The report recommended that efforts should be made to reduce the administrative burden on doctors undergoing revalidation, ensuring that they have sufficient time and support to meet their supporting information requirements, and to help them focus on their personal development.

References

THE RELATIONSHIP BETWEEN CULTURE AND COMMUNICATION IS COMPLEX AND DYNAMIC

Revalidation for anaesthetists

Taking revalidation forward

Chris Kennedy, RCoA CPD and Revalidation Co-ordinator

In the November 2016 issue of the Bulletin, it was mentioned how two important future milestones would be the publication of national reports evaluating the impact of revalidation.

The first of these, ‘Taking revalidation forward – Improving the process of relicensing for doctors’ (http://bit.ly/2wFuGyS), was written by Sir Keith Pearson, Independent Chair of the GMC’s Revalidation Advisory Board, and published on 13 January 2017. This report was developed following consultation with a variety of stakeholders including the medical Royal Colleges and Faculties, the British Medical Association, NHS Employers, and a number of patient groups.

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The report recommended that efforts should be made to reduce the administrative burden on doctors undergoing revalidation, ensuring that they have sufficient time and support to meet their supporting information requirements, and to help them focus on their personal development. It also described how there have sometimes been different local requirements going beyond what is specified by the GMC.

Sir Keith commented: ‘Very few people suggested to me that revalidation should be radically overhauled. People want to see evolution rather than revolution; I think that is the right approach’. A collaborative approach, including the GMC, the UK governments, healthcare organisations, and the Medical Royal Colleges and Faculties will be adopted to take action on the recommendations made.

We look forward to participating in this work, and also to developing new initiatives such as an enhanced CPD system under the College Technology Strategy Programme. For further information please visit the Revalidation Guidance section of our website or contact revalidation@rcoa.ac.uk.’
Faculty of Pain Medicine (FPM)

Report from the Professional Standards Committee

Dr Paul Wilkinson,
Chair, FPM Professional Standards Committee, Newcastle

It is an honour to take over as Chair of the Faculty of Pain Medicine Professional Standards Committee (FPMPSC) from Beverly Collett OBE, and I thank her for the work that she has done and for her successful leadership. Beverly was insistent on attending the RCoA Professional Standards Committee meetings to provide a symbiotic relationship, and I will ensure that this healthy rapport continues.

The FPMPSC has responsibilities for ensuring best standards in the practice of pain medicine, and, in addition to the wide range of documentation already published, imminent new publications include a collaborative document with the British Pharmaceutical Society on epidural steroid safety guidelines, patient-information leaflets for interventional procedures, and a checklist for intrathecal refills.

The Faculty has an important societal role, and must work with other professional stakeholders to facilitate role, and must work with other

There is a perceived shift of responsibility from patients determining their own ‘fitness to drive’, to determination through a medical diagnosis. Pain medicines may lead to sleepiness, but similarly, poor sleep may be helped by good pain relief.

Collaboration with the DVLA has been initiated to provide optimal advice for this complex problem.

Treatment of pain in prison has been a long-standing problem, with the risk of diversion of medication – especially Opioids or Pregabalin. And yet, pain treatment is a human right. The ‘Pain in Secure Environments’ course addresses these issues, and provides tools for prison staff.

Exploratory work on cross-specialty standards in pain and palliative care is being undertaken in partnership with the oncology and palliative care specialties.

‘Care Standards for Pain Medicine Services’ was launched in 2015. The standards cover both primary and secondary interdisciplinary care, working closely with other specialties to achieve these stated aims. A gap-analysis tool is currently being produced.

The far-reaching work of the FPMPSC will continue to contribute to the value and importance of the RCoA’s work as a whole.

Faculty of Intensive Care Medicine (FICM)

Critical Futures

Dr Anna Batchelor,
Past Dean, Faculty of Intensive Care Medicine

The Department of Health Review ‘Comprehensive Critical Care’, published in 2000 [http://bit.ly/2jy1Uq], introduced the concept of ‘critical care without walls’ – a service responding to the needs of all critically ill patients, whatever their location in the hospital.

We have seen dramatic changes. But where are we going next? What is the future for critical care medicine? FICM asked and almost 450 members of the ICM community completed an open questionnaire.

Some general themes are emerging from rather a lot of information.

- Workforce – despite an increase in the number of trainees in ICM, the number is still a long way from being able to supply enough CCT holders. Trainee staffing is also problematic. A particular stressor in smaller units is the need to provide a seven-day intensivist service with too few consultants.

- The place of consultants in anaesthesia as part of the ICM workforce solution attracts very polarised views.

- Many respondents are keen to train and/or recruit advanced critical care practitioners to bridge the trainee gap.

- Nurse staffing is a problem, with units unable to open funded beds because of recruitment difficulties. Overseas recruitment, a particularly popular strategy, may become more difficult if immigration controls are increased.

- Increased referrals, particularly of older patients with multiple co-morbidities; difficulty discharging patients; and the increasing pressure to make decisions about the value or not of critical care admission, are seen as onerous and stressful.

- Increasing demand for admission after elective surgery has led to several innovative solutions to avoid cancellation of surgery whilst preserving critical care beds for emergency cases.

- Reconfiguration of services is viewed as inevitable, with views divided on whether this is desirable or not.

- There is a strong view that DGHs are an important part of the service, and that referral of acutely ill patients will devalue and undermine them.

Sustainability and Transformation Plans may lead to hasty reconfiguration; it is concerning that critical care is facing increasing demands in the face of insufficient staffing. Costly and disruptive service changes may add to the problems we are already facing.

NHS intensive care ‘at its limits’ because of staff shortages

The RCoA and FICM featured in a Guardian article on Sunday, 29 January, responding to Intensive Care Unit under-staffing, bed shortages, cancelled operations and the impact on patients.

Dr Liam Brennan, President of the RCoA, said: ‘In order to care for acutely unwell patients, surgery is being postponed because of lack of ITU beds. The combination of inadequate staffing levels in ITUs together with a shortage of high-dependency beds is having a very real impact on patients, which are needing to have critical surgery such as major abdominal or chest surgery, or neurosurgery, delayed for their own safety.’

SNAP-2: EPIDEMIOLOGY OF CRITICAL CARE PROVISION AFTER SURGERY (EPICCS) COMING TO YOUR HOSPITAL SOON!

In the January 2016 issue of the Bulletin, we laid out plans for the 2nd Sprint National Anaesthesia Project (SNAP-2), and discussed the reasons for carrying out the study.¹ One year on, we are about to launch and so we are giving this update and information on how to get involved.

Preparation for lift-off

Engines are warming up for the study to recruit patients from Tuesday, 21 March to Monday, 27 March 2017, with a one-week follow-up of the patients ending on Monday, 3 April 2017. We will collect data on all inpatients undergoing surgery during the recruitment week, through the use of a questionnaire completed at the time of surgery by the perioperative anaesthetist. The information collected will include patient demographics, baseline risk information according to validated risk calculation tools, surgical procedure type, where the planned postoperative destination is, and so on. We plan to then assess the patients’ postoperative morbidity and mortality outcomes by following patients up after a week postoperatively, and then by linking their prospectively collected data to the NHS Digital/Office of National Statistics mortality registries for longer-term outcomes.

The questionnaires will then be collated and the data uploaded onto a secure web database, which would look familiar to those of you involved with collecting data for SNAP-1, the National Emergency Laparotomy Audit (NELA) or the Perioperative Quality Improvement Programme (POQIP). We anticipate that the system will be straightforward and easy to use, but we will be on hand to answer any questions that may arise through email, telephone or Twitter.

All systems go

We have piloted the study at two sites, University College London Hospital and Derriford Hospital in Plymouth, to identify any potential obstacles to running the study UK-wide in March. At the time of writing, we have 216 hospital sites throughout the UK signed up to participate, spread across all four devolved nations (Figure 1). Consultant Principal Investigators (PIs) are rallying their departmental colleagues, and the Research and Audit Federation of Trainees (RAFT) have also asked for the support of the trainee research networks to assist with running the study locally. All the preparations have involved hundreds of individuals up and down the UK, and we are grateful for the enthusiasm that everyone has shown for the study! This is truly a testament to the great things the UK anaesthetic community can achieve from working together.

Fasten your seatbelts

A lot of effort has gone into preparing for SNAP-2, and we hope it will provide potentially important information to guide our use of postoperative critical care. At this point we have done as much as we can to help the project fly, but whether it succeeds will depend largely on the hard work of the anaesthetists at the frontline, who are the wind in our sails. If you are reading this article and have yet to be involved, now is the opportunity to find out more about why and how you can be a part of this great endeavour:

- all collaborators will have their names included in PubMed listings for any publications that arise, following the publication model we pioneered in SNAP-1²,³
- trainees working in hospitals with active trainee research networks can approach their local networks for more information: [http://bit.ly/2I1mcAw](http://bit.ly/2I1mcAw)

Dr Danny Wong, Anaesthetic Registrar, South East School of Anaesthesia, and NIAA HSRC SNAP-2 Fellow

Dr Ramani Moonesinghe, Director, NIAA Health Services Research Centre (HSRC)

Figure 1 Map of registered SNAP-2 Study Sites
Professor Kate Leslie, seated centre
with the ANZCA Council, ANZCA House, Melbourne, 2010

Growing the next generation of anaesthesia research leaders is one of the principal responsibilities of the current leadership in our specialty. I am honoured to be invited to speak on this subject in delivering the John Snow Oration at the College’s Anniversary Meeting on 8 March 2017.

Like many investigators the seeds of my interest in medical research were sown in childhood. My parents, a nurse and an agricultural scientist, their friends, and my teachers, encouraged me to pursue science subjects at school. I was attracted to anaesthesia by the combination of basic science, procedural medicine and teamwork. However it was the anaesthesia primary examination that catapulted me into research. I became fascinated by pharmacokinetics and dynamics, and in particular the work of Holford and Sheiner on the dose-effect relationship, and volunteered to work with Dr David Crankshaw at the Royal Melbourne Hospital on his proposol research. I still have the ethics application for my first project in my archives. It’s five pages long with a one-page patient information and consent form. Dr Crankshaw was very generous with his time and expertise, and very patient with my nascent computer skills. I managed to sign up 148 patients in six months with no refusals, and after rigorous [but kind] reviews published two papers from this work within the year. These were the days!

When I finished anaesthesia training in Australia, I moved to a research fellowship with Dr Daniel Sessler in the Department of Anaesthesia, University of California San Francisco (USCF). I worked with Dr Sessler on thermoregulation, and was involved with early studies on the Bispectral Index (BIS) monitor. I was intrigued by the window that the BIS provided into anaesthetic action and its potential to prevent awareness. Because all these studies involved propofol, I was able to write them up into a Doctor of Medicine thesis (an example of the benefit of being focused in research). However, the best thing about USCF was the people: inspiring role models, generous sponsors and mentors, and great friends. There was also dining out, skiing and partying... halcyon days!

I returned to my consultative position at the Royal Melbourne Hospital as collaborative clinical trials in anaesthesia took off in Australia. Our first study, initiated in the mid-1990s by Dr John Rigg, was the MASTER trial comparing epidural with intravenous analgesia in high-risk patients having major non-cardiac surgery. Following the successful completion of this trial, the Australian and New Zealand College of Anaesthetists (ANZCA) established the ANZCA Clinical Trials Network (CTN) (www.anzca.edu.au/ctn), funding a full-time manager and office and appointing Professor Paul Myles FRCA (Hon.) as the inaugural chair. B-AWARE, ENIGMA-I and -II, POISE-1 and -II (in collaboration with the Population Health Research Institute at McMaster University, Canada) and ATACAS followed. We are currently recruiting to the Balanced Anaesthesia study, RELIEF, PADDI, ITACS and ROCKET, all funded by ANZCA and the National Health and Medical Research Council of Australia. In total we have received over A$25M in peer-reviewed funding and have recruited more than 30,000 patients to ANZCA CTN-endorsed projects.

I have been asked many times how this successful network was established and is sustained. I don’t think that there is anything uniquely Antipodean about an ability to work together towards a common goal. The first step was to embrace the fields of epidemiology and statistics as the foundations of clinical trial research. Like others I completed a master’s degree in epidemiology when I returned to Australia, and I highly recommend that future research leaders complete a degree like this before their MD/PhD. The second step was to engage ANZCA and its Fellows in our vision to be a world leader in clinical trial research that makes a difference to patients’ lives. This embeds research as a fundamental activity for trainees and specialists to participate in or support. In this regard it was important that researchers (such as myself) were elected to the council and presidency of the College. The third step was to be generous in terms both of sharing resources (especially funding) and of sharing opportunities to make a big contribution and take credit for the successful outcomes of our research. The final step was to enjoy the whole research journey and the people who make it happen. The frustrations and disappointments that are part and parcel of clinical research in the 21st century are only bearable with a little help from your friends!

I hope that this short reflection on my career in anaesthesia research will inspire emerging researchers to become leaders in collaborative research. I look forward to expanding on these ideas in the John Snow Oration at the College’s Anniversary Meeting on 8 March 2017.

References

Health Services Research Centre (HSRC)
GROWING THE NEXT GENERATION OF LEADERS

Professor Kate Leslie, Head of Research, Royal Melbourne Hospital; Chair, Australian and New Zealand College of Anaesthetists Clinical Trials Network Executive

Growing the next generation of anaesthesia research leaders is one of the principal responsibilities of the current leadership in our specialty. I am honoured to be invited to speak on this subject in delivering the John Snow Oration at the Anniversary Meeting of Royal College of Anaesthetists on 8 March, and to reflect on my career in anaesthesia research in this edition of the Bulletin.

Like many investigators the seeds of my interest in medical research were sown in childhood. My parents, a nurse and an agricultural scientist; their friends, and my teachers, encouraged me to pursue science subjects at school. I was attracted to anaesthesia by the combination of basic science, procedural medicine and teamwork. However it was the anaesthesia primary examination that catapulted me into research. I became fascinated by pharmacokinetics and dynamics; and in particular the work of Holford and Sheiner on the dose-effect relationship, and volunteered to work with Dr David Crankshaw at the Royal Melbourne Hospital on his propofol research. I still have the ethics application for my first project in my archives. It’s five pages long with a one-page patient information and consent form. Dr Crankshaw was very generous with his time and expertise, and very patient with my nascent computer skills. I managed to sign up 148 patients in six months with no refusals, and after rigorous [but kind] reviews published two papers from this work within the year. These were the days!

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References
As the Sustainability and Transformation Plans unfold and the NHS hurtles towards another bout of change, I can see the old PowerPoint slides being dusted off, with their claims of:

- design around the patient
- devolved responsibility
- clinical leadership
- integrated care
- less bureaucracy.

Heard it before? Can we make it different this time?

Can we learn from some of the big mistakes that were made in the past?

I am reminded of the Staffordshire Hospital scandal that engulfed the NHS and the subsequent Francis Report, published in 2013 – only four years ago, but it seems like decades, don’t you think? At the time of writing, the NHS appears to be under even greater pressure. The Sustainability and Transformation Plans for the NHS are likely to further ratchet up those pressures, yet I doubt that many of the proposals will address the lessons of previous failures in a systematic way.

I am reminded of the George Santayana quotation: ‘Those who cannot remember the past are condemned to repeat it.’

One fundamental question remains. How could highly trained, professional doctors and nurses who are empathetic to the events which took place in a Foundation Trust be economically sound? This financial imperative became all-consuming and overshadowed the other objectives of the hospital, including, of course, providing safe patient care. The systemic pressures forced members of staff into unacceptable behaviour and deprecation of duty.

How do we avoid such an occurrence now? At the time of writing, the NHS seems to agree that ‘this must not happen again.’

A culture change was required and the NHS ‘machinery’ cranked into action, busily attempting to action the hundreds of recommendations made by Sir Robert Francis QC.

One fundamental question remains. How could highly trained, professional doctors and nurses, who provide care for us, be economically sound?

I suppose it is now consigned to the bookshelf of NHS failures, and gathers dust alongside other similarly worthy tomes.

The focus of the scandal at Mid Staffordshire NHS Foundation Trust was the poor care and high mortality rates of patients. The levels of neglect of patients at the hospital that were revealed – for example, that some nurses had left patients sitting in their own urine – were widely criticised and considered deeply shocking.

Heads rolled, and everyone seemed to agree that ‘this must not happen again’. A culture change was required and the NHS ‘machinery’ cranked into action, busily attempting to action the hundreds of recommendations made by Sir Robert Francis QC.

One fundamental question remained. How could highly trained, professional doctors and nurses allow such a state of affairs to develop?

One underlying cause appeared to be the Trust’s determination to achieve Foundation status, alongside the ever-present need to make it different and to implement or affect by them.

There are many examples of policies adopted and failing because they were too remote from the reality on the ground and did not take account of the experience of those either implementing or affected by them.

Healthcare is one area of life where empathy really does matter. But financial, staffing and access pressures can make empathy seem hard to achieve. For the NHS – a service which was founded on the ideal of social solidarity, is supported by the public ethos of its workforce, and which owes its existence to continued public support – this matters a lot.

A wide range of evidence shows that doctors and nurses who are empathetic tend to provide better care. Studies also suggest, unsurprisingly, that patients place a very high value on being treated with dignity and respect.

It also matters that people have empathy with those who work in the NHS. The recent NHS Staff Survey in England showed troubling levels of abuse. More than one-third of nurses reported being subject to bullying, harassment or abuse from patients or their relatives. One in four of the NHS workforce reported bullying or abuse from other colleagues.

One in four of the NHS workforce report bullying or abuse from other colleagues.

One of the ways in which we spend our time and those who provide care for us, we should also consider how empathetic we want our politicians and leaders to be. We do want them to be objective and to be able to make tough decisions if necessary, but surely we don’t want them to be heartless. Current thinking points to different types of empathy, including:

- ‘emotional empathy’ (feeling someone’s grief) is important, but cannot by itself be the basis of moral judgments because it biases us towards those who are most visible
- ‘cognitive empathy’ (understanding the perspectives of others) appears to be fundamental to good decision making.

Empathy has limits for healthcare professionals too. I suspect that most patients would want their doctor to understand how or why they fell, but this would not extend to wanting their doctor to cry at the same time as they cry. They also want the doctor to remain calm in an emergency, even if the patient herself does not. And for the clinician, a degree of professional detachment is necessary.

Funding and staffing shortages will continue to put enormous pressure on the NHS over the next few years. Getting through this will rely on the wellbeing and resilience of all staff, and this includes senior hospital and health service management as well as those directly providing care. Making it through will also require the ability to stand in somebody else’s shoes, if we are to avoid some of the tragic mistakes of the past.
In October 2016, the College ran its successful day for Medical Training Initiative (MTI) doctors, recently arrived for their two-year stay to study in the UK. The College also invited SAS doctors who were new to the NHS as well. The two groups shared the morning, and then split into two groups in the afternoon to focus on subjects of particular interest to each.

The number of SAS doctors was quite small, but all appreciated the opportunity to visit the College and meet colleagues with similar experiences. The delegates came from a variety of countries including Sri Lanka, Poland, Hungary and South Africa. Many trusts have been actively recruiting from abroad to try and make up the numbers for rotas and elective work.

The NHS is unique. Its culture, and that of the country more widely, can be quite a shock to new doctors from abroad. In the past, many have been left to fend for themselves, but there is now an increasing trend towards a more formal orientation and induction period. The College day aims to complement this, and to give an opportunity to meet others in a similar situation. It can be a lonely experience if you have no friends or family in the country and so much that is new to cope with.

The morning session started with an excellent talk from John Davey from the GMC. Medical regulatory systems vary between countries. Familiarity with how things work in the UK can help individuals to practise in accordance with our national standards and avoid problems due simply to misunderstandings or lack of knowledge. Doctors from abroad are over-represented in Fitness to Practise proceedings at the GMC. Delegates were able to pick up hard copies of GMC guidance documents, which are available on its website.

Some SAS doctors consider taking the fellowship examinations. David Rowand, from the College’s Education, Training and Examinations Directorate, explained what resources are available to assist in preparation. Dr Sujesh Bansal then gave some advice on how to make the most of educational opportunities within anaesthetic departments. As well as joining regular teaching when possible, it helps to be proactive in offering to teach. For SAS doctors, there will always be less experienced junior colleagues or medical students. There are increasing numbers of simulation facilities around the country, as well as national courses such as Advanced Life Support and Paediatric Advanced Life Support. Teaching is one of the best ways to learn and consolidate knowledge. Look out for local courses in non-clinical subjects. These are often cross-specialty and free or at minimal cost. Your hospital SAS Tutor should be able to keep you up to date.

In the afternoon, the SAS doctors shared experiences of being new to medicine in the UK. The main take-home message was that you should never be worried about asking for help. Every anaesthetist should work within their competence, whatever their experience. This is an area where cultural differences and language can have a significant impact. Most of the delegates felt they had been well supported. The College SAS Committee would recommend that all new SAS doctors have a mentor; this can be arranged to suit both parties but it should be a non-judgemental and supportive relationship, giving a safe space to reflect and discuss difficulties and success.

RCoA SAS Council member, Dr Kirstin May (above left), took us through access to the Specialist Register via the Equivalence process (CESR). It is a lot of work, taking up to two years. Even if you have covered all the areas of the training curriculum, you must provide the evidence to demonstrate this. About half of applicants are successful. Kirstin sits on the College Equivalence Committee. All documentation is submitted to the GMC and then passed to the College for review. More information is available on both the GMC and College websites.

The day finished with photos and a drinks reception, and most delegates enjoyed the chance to chat and network. We hope that this day can be repeated in 2017, and that more SAS doctors will attend as part of their introduction to working in the NHS. Please let us know of any topics you think should be included by contacting sas@rcoa.ac.uk.

Dr Lucy Williams, RCoA SAS Member of Council

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Staff, Associate Specialist and Specialty Doctor (SAS)
Staff, Associate Specialist and Specialty Doctor (SAS)

CESR – SHOULD YOU? COULD YOU? WOULD YOU?

Dr Kirstin May, RCoA SAS Member of Council

‘Nothing in the world is worth having or worth doing unless it means effort, pain, difficulty...’

THEODORE ROOSEVELT

‘Equivalence describes the process of assessing an applicant’s training and experience against the current training programme requirements, as set out in the CCT in Anaesthetics, in order to gain a Certificate of Eligibility for Specialist Registration (CESR) for the Specialist Register held by the General Medical Council.’

RCoA WEBSITE

Since I joined the College Council in March 2015 representing SAS colleagues, almost all questions I have been asked by colleagues are along the lines of: ‘I am interested in applying for CESR. Can it be done? Does anyone ever get through? Should I do it?’ Therefore, I thought it would be helpful to share my experience as a member of the committee assessing the applications, not to be read as official guidance but intended to give you some insight into the process.

At the College

Applications are made to the GMC, where submitted documents are checked thoroughly before being forwarded to the Equivalence Committee at the RCoA. The Committee then assesses the application via a secure GMC portal. The Committee includes SAS and lay representatives. Every effort is made to assess all applications received from the GMC at the Committee meeting following their receipt by the College (meetings are held monthly). Individual Committee members assess the applications, first separately – probably in the comfort of their own homes. The application is then discussed by Committee members in a meeting. The discussions are frank. Reassuringly in my experience we have always reached a unanimous decision. Applications are extremely large documents, and assessment of them is a mammoth task – especially when it is borne in mind that it is done by unpaid volunteers. During my first year I have seen applications ranging in size from 500 to 1900 pages.

Areas of difficulty

Applicants must meet the standards of training and clinical experience as set out in the CCST curriculum. Often applications fall short in areas of higher training in subspecialties such as Paediatrics, Neurosurgery, Intensive Care Medicine and Cardiothoracic Anaesthesia. It is wise to familiarise yourself with the current training curriculum to assess your position before you embark on the process. Please refer to guidance on the GMC websites.

Many successful applicants have complemented previous training and experience with further attachments, with assessments as required in these areas. For many applicants this has involved day-release, or time out of their usual jobs spent instead working in specialist areas.

If you have worked independently for many years, it can feel awkward to ask for formal assessments by colleagues, especially if you – the applicant – are used to assessing trainees. Work in or attachments to specialist areas are not easily organised, and may well require personal and/or financial sacrifice. It may be difficult to persuade your employer to release you for this unless they are keen to employ after you have been successful. However, it may be worth emphasising to the employer and colleagues that every doctor should seek and undergo further training to remedy the shortfall. The success rate is slightly above 50% with an upward tendency over the last few years.

Myths

Doctors considering an application often compare their practice with that of consultant colleagues in their department. A favourable comparison in their own eyes or a well-meant comment such as ‘you should/could be a consultant’ may lead to unrealistic expectations regarding the outcome of an application. An assessment for Equivalence is not an assessment of whether you are a good anaesthetist or not, nor is it a popularity contest. The assessment is based on whether or not the applicant’s experience and training is equivalent to the current training programme requirements. This is particularly important to bear in mind for the structured references.

Is it worth it?

Undoubtedly there is a lot of work involved in successfully completing the process. This leads many to believe this is an almost insurmountable and possibly unfairly high hurdle. It is important to remember that trainees taking the usual route to the Specialist Register also accumulate masses of paperwork in the process and make personal and financial sacrifices. Some doctors feel CESR is not treated as truly equivalent to CCT when applying for consultant posts. It is certainly possible to meet the criteria for Equivalence without being a strong competitor when applying for jobs that are desirable or in desirable areas of the country. Before applying for consultant posts, it is advisable to invest energy into putting yourself into the best possible position for the market. Again, the same applies to trainees following the usual training route.

Even SAS doctors who have made it onto the Specialist Register may choose not to work as consultants. However, some tell me they feel a sense of personal achievement and greater self-confidence after going through the process successfully. Of course personal circumstances can also change.

The College has approached some recently successful applicants to find out how their careers have subsequently developed. We are still collating responses and are yet to hear from a number of applicants. If you have been successful and would like to share your experience of the application process, please contact us. We are also interested to hear what has subsequently happened to your career.

However, before you write to us, remember the basic framework comes from the GMC, not the College.
One afternoon in June last year, I found myself nervously walking across Red Lion Square ...

The Perioperative Medicine Fellowship

Thankfully, on this occasion there were no tricky physics or anatomy questions, and I was fortunate enough to be appointed as the first Royal College Fellow in Perioperative Medicine. After negotiating the usual administrative hurdles, I started the post in January. This article describes the role of the Fellow and plans for the year ahead.

The primary role of the Perioperative Medicine (POM) Fellow is to support the Clinical Leads (Dr Chris Snowden and Dr Mike Swart) in implementing the Perioperative Medicine Programme. In practice the post is evolutionary, reacting to developments and opportunities as they arise. It comprises 50% clinical work and 50% College work. On the clinical side there are supervised preassessment and shared decision-making clinics, management of high-risk patients, cardiopulmonary exercise testing, and taking active roles in multidisciplinary meetings, as laid out in the curriculum for Advanced Training in Perioperative Medicine. On the College side, I attend Leadership Group and Innovation Group meetings, help run events, participate in quality improvement projects, present roadshows, deliver teaching, and represent trainees’ views to the Leadership Group. We intend to organise an event for trainees looking to form a blueprint for developing POM Fellowships and modules in interested hospitals.

Local Leads

In mid-2015 the College asked all trust Clinical Directors to nominate a Local Lead for perioperative medicine, and we now have over 160 departments represented. The Leads were surveyed, which identified the provision of perioperative services across the UK and established their priorities for service development. In January we held a popular event for the Local Leads where we explored these themes further and heard some examples of innovation in service development from across the country. Our longer term aim is to create networks whereby practice, pathways and business cases can be shared across the country, in the hope that we can learn from each other and make introducing change easier. The full results of the survey and the outcome of the event will be reported in a later issue of the Bulletin.

Themes for the year ahead

The ‘top six’ areas we will be concentrating on are:

- management of perioperative anaemia
- shared decision making
- development of the perioperative team
- collaboration with primary care
- postoperative mortality prediction
- frailty and cognitive impairment

In the first instance we will be developing ‘toolkits’ for trusts who are keen to develop their anaemia pathways, drawing on experience from those who have implemented them successfully, as well as providing support for measuring effectiveness of these interventions. We are in discussion with other Colleges to develop cross-specialty collaboration on shared decision making, which we hope will be constructive and potentially lead to the creation of a workshop for all specialties involved in perioperative medicine.

Education and Training

August 2016 saw the introduction of perioperative medicine into the Curriculum for Anaesthesia (www.rcoa.ac.uk/curriculum). The College believes that all hospitals providing anaesthetic training are in a position to deliver this component of the curriculum, though at first glance it may appear daunting. In many respects, the curriculum formalises existing practice. We encourage feedback from units on any challenges they feel they are facing, and are happy to assist in the development of perioperative medicine modules and fellowships. Opportunities to deliver this training exist both inside and outside theatre, as well as in surgical clinics, orthopaedic ward rounds, pain clinic, critical care outreach and High-Dependency Unit ward rounds amongst others. An FAQ for curriculum implementation and delivery is on the perioperative medicine website. The College is collaborating with the authors of a Massive Open Online Course (MOOC) in perioperative medicine. More information on the MOOC and how to access it will be added to the microsite in the coming months.

In summary, 2017 promises to be busy for the Perioperative Medicine Programme. The Leadership Group are keen that we provide support for, and help facilitate, improvements in perioperative care rather than issuing edicts on how units should implement the programme. To help us in this, we welcome feedback, ideas and examples of innovation and best practice, so please contact us via the website.

Dr Anne-Marie Bougeard, RCoA Perioperative Medicine Fellow, ST5 Anaesthesia, Torbay Hospital

THE PERIOPERATIVE MEDICINE PROGRAMME
Leadership and management development can result in competencies and skills which facilitate change, be it to improve quality of care for our patients, make clinical systems safer or more efficiently use resources and minimise waste. It may take the form of a business case, the design of a novel patient care pathway or a quality improvement initiative.

Shared leadership is where there is a collective sense of responsibility for the success of the organisation and its services. It is attractive because it aims to empower everyone. In 2008, the Medical Leadership Competency Framework, built on this concept of shared leadership, was introduced (see Figure 1). It describes the leadership competencies that doctors need to become more actively involved in the planning, delivery and transformation of health services. The Healthcare Leadership Model was later developed with a focus on the nine dimensions of leadership behaviours (see Figure 2). Clinicians, consultants and trainees alike should examine these fundamental competencies and behaviours to consider what the next step for their leadership and management development should be.

Courses
Courses can be aimed at those at the start of their leadership journey or at those who want to consolidate and further their learning. Some courses are face-to-face while others are delivered online. Those that take an extended period of time tend to lead to some sort of formal qualification. Further details about available courses that we have found valuable, though by no means an exhaustive list, can be found in Table 1.

Local initiatives
Opportunities for leadership and management are available at every hospital in the development, evaluation and improvement of service provision. Trainees themselves can suggest and introduce change; they see what works and what does not work as they move from hospital to hospital with a fresh pair of eyes. In many healthcare organisations it is also possible to shadow clinical and non-clinical leaders and managers as part of a formal or informal programme.

Trainees should be encouraged to approach the department in which they work for experiences of this nature.

Fellowships
The Darzi Fellowship in Clinical Leadership and the National Medical Director’s Clinical Fellow Scheme are well-recognised national initiatives. They are ideal for those looking to take on large-scale leadership projects in established organisations. For those thinking more outside the box, opportunities in areas such as management consultancy can be extremely valuable on re-entering clinical practice.

Table 1 Summary of some courses available in leadership and management

<table>
<thead>
<tr>
<th>Course</th>
<th>Institution</th>
<th>Delivery</th>
<th>Length</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Leadership and Management: The Essentials</td>
<td>RCoA</td>
<td>Face-to-face</td>
<td>Two days</td>
</tr>
<tr>
<td>Management and Leadership Course</td>
<td>AAGBI</td>
<td>Face-to-face</td>
<td>Two days</td>
</tr>
<tr>
<td>Clinical Leadership and Management Course for Anaesthetists</td>
<td>Keele University</td>
<td>For trainees: Face-to-face</td>
<td>Three days</td>
</tr>
<tr>
<td>Leadership Development Programme for Consultants</td>
<td>Keele University</td>
<td>For consultants: Face-to-face</td>
<td>Two days for foundation module and a further two days for advanced module</td>
</tr>
<tr>
<td>Edward Jenner Programme: NHS Leadership Academy Award in Leadership Foundations</td>
<td>NHS Leadership Academy</td>
<td>Online</td>
<td>Six weeks for two modules</td>
</tr>
<tr>
<td>Mary Seacole Programme: NHS Leadership Academy Award in Healthcare Leadership</td>
<td>NHS Leadership Academy and Hay Group</td>
<td>Face-to-face and online</td>
<td>Six months for 12 modules</td>
</tr>
<tr>
<td>Postgraduate Certificate in Healthcare Leadership and Management</td>
<td>Keele University</td>
<td>Face-to-face and online Three modules</td>
<td>Minimum of one year</td>
</tr>
</tbody>
</table>

Professional bodies and societies
Constituted by the Academy of Medical Royal Colleges, the Faculty of Medical Leadership and Management is the professional body for medical leadership in the United Kingdom. It is a rich source of information and provides members with access to conferences, coaching and networking. Membership is varied and ranges from medical students to chief executives. Other bodies exist and further information can be found in a previously published article.

In 2012, Leadership Development for Anaesthetists (LD&A) was established by a group of anaesthetic trainees in London. It is now supported by the London Academy of Anaesthesia. Its aim is to support trainees meet the requirements of the Royal College of Anaesthetists’ Annex G of the curriculum. Regular presentation evenings are hosted at the London Deanery, and previous themes have included finance, quality improvement, and the writing of business cases. In association with the Pan-London Perioperative Audit and Research Network (PLAN), the LD&A has put together and delivered a post-FRCA
study day for anaesthetic trainees. In order to provide information to trainees in the lead up to consultant interviews, the website, www.ldfa.co.uk, has relevant articles and up-to-date news of leadership issues (see below).

If readers would be interested in setting up a similar facility in their region, we ask them to get in touch.

Mentoring

Becoming an effective and competent leader and manager needs guidance and nurturing. To this end, finding a mentor is strongly advised and current clinical leaders and managers should welcome those who show an interest.

Conclusions

Development of leadership and management competencies and behaviours is a journey of discovery. In recognition of the importance of leadership and management, courses, fellowships and other resources are increasing in number. Clinical application of these competencies and behaviours should bring about improvements in the care we provide to patients and in the organisations we work for.

References


Figure 2 The nine dimensions of the Healthcare Leadership Model. NHS Leadership Academy, 2013. All rights reserved.
This component of the curriculum is delivered in many differing and often ad hoc guises across UK Schools of Anaesthesia. In East of Scotland we have drawn upon a number of these programmes and devised an inclusive, spiral-learning management programme incorporating the goals of trainee engagement, paired learning and professional development within a structured delivery of Annex G through an advanced management and leadership fellowship. The King’s Fund report, ‘The Future of Leadership and Management’\(^2\) emphasised the need to encourage clinicians to engage in the process of developing leadership. ‘Train to board to ward’ Spurgeon et al found that levels of medical engagement in secondary care management structures correlated strongly and positively with hospital mortality rates, patient safety, financial performance and CQC scoring.\(^3\)

‘Learning from Serious Failings in Care’ (Academy of Medical Royal Colleges in Scotland, 2010) examined a number of national reports into ‘failing’ hospitals, and identified key contributing common features, including poor leadership from medical staff, focusing on their training. Each role has an assigned consultant lead to set SMART goals, monitor progress, mentor trainees and encourage reflection, with direct mapping to Annex G care competencies. Through validation of these roles and creation of novel Advanced Management Fellowship (Tier 3), we aim to provide scope for those wishing to further develop this aspect of their training.

The Advanced Fellowship (Tier 3), run within ST6/7 training at one or two sessions per week, combines the following features:

- delivery of a significant, tangible piece of improvement work that makes a meaningful difference to patient care
- linking with clinical and non-clinical management via supported paired learning, as described by the Imperial College toolkit (http://imperial.manpower.org.uk)
- collaboration on a bespoke project at a departmental or trust level for a period of six months, with projects ideally linking in with the individual trainees’ sub-specialty interests or past-CCT plans
- involving the trainee in relevant board and national-level management in order to better understand the higher functions and strategic goals of the NHS in Scotland
- ultimately generic management skills, such as negotiation, team working and problem solving, will be supplemented by a working knowledge of how to apply these skills to construction of a business case working within financial constraints, and to navigation of the structures and functions of the NHS. Development of the structured three-tier programme and the Advanced Fellowship was initiated by senior trainees already participating in local and national management and leadership roles, in conjunction with clinical leads and clinical services managers for anaesthesia, and working with support from one of the SCLF national programme leads from the Scottish Government Health Department. This has required liaison with and support from others for specific aspects of the programme, including local paired-learning opportunities, support from consultants overseeing each Tier 2 role, and engagement with the local RCoA to sanction additional time required to undertake advanced management programmes alongside clinical duties.

The RCoA Regional Advisor and Training Programme Director was supportive of improving delivery of Annex G training, and specialty training committee approval and recognition has been obtained for both the Programme and the Advanced Fellowship within the context of the current training curriculum.

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**Figure 1** Tayside Anaesthesia Structured Management and Leadership Training

**Tier 3 - Advanced Management & Leadership Fellowship:**
- Health services undertaking during ST6/7: clinical, clinical leadership, management
- Including bespoke management & leadership project developed in conjunction with the Local Leadership & Management Team, NHS, Scottish Government or RCoA
- Ongoing wide experience of departmental, trust and national-level service planning and development. Paired learning with clinical and non-clinical managers
- Progress towards RCoA 2010 Curriculum Annex G Advanced level management competencies

**Tier 2 - Developing Management & Leadership Skills:**
- Aim to gain experience in departmental management roles (Tier 3) and leadership skills.
- Ongoing paired-learning opportunities, support from others for specific aspects of the programme, including local paired-learning opportunities, support from consultants overseeing each Tier 2 role, and engagement with the local RCoA to sanction additional time required to undertake advanced management programmes alongside clinical duties.

**Tier 1 - Basic Management & Leadership**
- Involves development of leaders with no formal additional experience gained

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**WE AIM TO TRAIN A COHORT OF FUTURE LEADERS WHO ARE EQUIPPED TO DEAL WITH UNDERTAKING MANAGEMENT ROLES AS CONSULTANTS AND BEYOND SHOULD THEY WISH TO PURSUE A CAREER IN SENIOR MANAGEMENT**
In addition to supporting project work and paired learning, the Clinical Services Manager has allocated funding for attendance at specific RCoA leadership courses (www.rcoa.ac.uk/training) thus supporting formative teaching within the context of anaesthesia, in addition to the fundamental on-the-job experience. Through attendance at these courses, the Advanced Fellows will then feed back, peer-to-peer education directly to the remainder of the trainee body through post-fellowship teaching sessions.

Experience gained throughout all the Tiers of this programme should be pertinent to those transitioning into post-fellowship teaching sessions.

We aim to train a cohort of future clinical leaders within the NHS in Scotland, and will assist in guiding the next generation of trainees through this process.

For those trainees without a significant explicit interest in management, the three-tier programme offers a structured method of delivering and recognising all Annex G competencies. However, through development of this Programme and the Advanced Fellowship at NHS Tayside, and through formalising the recognition and reflection of roles already undertaken, we aim to ultimately encourage more trainees to develop management interests and skills, to engage with other professional groups, and to further breakdown the perceived barriers between clinicians and managers so evidently causing unnecessary tension and wasted energy in departments across the country.

Building these skills will improve professional confidence, promote clinical engagement, and focus the contributions of trainees as they progress through their careers to the benefit of patients, the health system and the specialty.

PARThicipation in the Advanced Fellowship will produce improved understanding of financial constraints and opportunities, along with enhanced leadership, motivation, and negotiation skills. These qualities vitally underpin the direct clinical-care work of a department, whilst looking to the long-term maintenance and development of patient services.

We aim to train a cohort of future leaders who are equipped to deal with undertaking management roles as consultants and beyond should they wish to pursue a career in senior management. Together with the Scottish Clinical Leadership Fellows, we will integrate and share experience in order to develop future clinical leaders within the NHS in Scotland, and will assist in guiding the next generation of trainees through this process.

For those trainees without a significant explicit interest in management, the three-tier programme offers a structured method of delivering and recognising all Annex G competencies. However, through development of this Programme and the Advanced Fellowship at NHS Tayside, and through formalising the recognition and reflection of roles already undertaken, we aim to ultimately encourage more trainees to develop management interests and skills, to engage with other professional groups, and to further breakdown the perceived barriers between clinicians and managers so evidently causing unnecessary tension and wasted energy in departments across the country.

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### References


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**Reflections on Military Anaesthesia Over the Last 25 Years**

Surgeon Captain Andrew Burgess, Royal Navy (Retired), Consultant Anaesthetist, Plymouth

Former Defence Consultant Advisor in Anaesthesia; Medical Director, Bastion; and Military Clinical Director Defence Medical Group SW (Plymouth)

Twenty-five years have seen a sea change in military anaesthesia. By 1992, the Cold War had finished, the first Gulf War had only just ended, Irish ‘Troubles’ were ongoing and the Bosnian war was just starting. Anaesthetic commitments persisted, although a different approach to manning and training existed then, with less operational theatre-specific training, and predominantly junior anaesthetists being tasked. This changed dramatically over the next few years...for the better.
Camp Bastion
Between 2005 and 2014 it was the logistics hub for International Security Assistance Force (ISAF) operations in Helmand during the War in Afghanistan and Operation Herrick.

In the early nineties, military anaesthetists trained alongside civilian colleagues, then joined units – capital ships, bases in Germany, or military hospitals. Trainees were frequently deployed (in their single-service environment) mid-training, and junior anaesthetists could find themselves the sole operators on aircraft carriers with 1,200 personnel (with an East Raddcliffe ventilator), in hospitals in Germany, Cyprus or Gibraltar, parachuting with their Tri-Service Apparatus strapped to their backs. Great experience ... with an element of fun ... but possibly not ideal in governance terms. ‘Calmanisation’ and military hospital closures in the 1990s had a dramatic effect, and resulted in the consultant-led service that we now recognise. Closures in Ely, Woolwich, Cambridge, Halton, Wroughton, Catterick, Gibraltar, Plymouth (and later, Portsmouth), led to civilian integration, and NHS-hosted Ministry of Defence Hospital Units were born, providing training and placements for military doctors, and healthcare to military personnel. Other than limited supervised deployments, trainees became ring-fenced until accredited. There was sadness and initial opposition at closures of much-loved establishments that engendered military ethos, standards and history and were, it has to be said, lovely places to work in. However, the quality, quantity, complexity, NHS integration and equality proved successful and led to major developments in Defence Anaesthesia over the following decades.

The idea that the Cold War’s ending heralded an era of world peace was off the mark, and subsequent commitments in Kosovo and Sierra Leone were an almost mild prelude to the whirlwind that hit in 2001 on 9/11, with the subsequent ‘war on terrorism’. Defence Anaesthesia (DA) and frontline specialties entered over a decade of intensity which has only now begun to settle but which has delivered year-on-year improvements in care, innovation, training, and lessons for the military and NHS, with research that has been second-to-none.

From late 2002, most military anaesthetists were deployed in Gulf War 2. Field Hospitals (Role 3) were set up in Kuwaiti deserts and later Iraq, manned by all three Services, both Regulars and Reservists, whilst smaller manoeuvrable units (Army/Royal Navy) provided Role 2 (life- and limb-saving) surgery with support to Special Forces and Royal Marine units. RFA ARGUS (complete with theatres, wards and significant intensive care facilities) provided Role 3 maritime hospital facilities, whilst the RFA’s Critical Care Air Support Teams (CCAST), run by anaesthetists and critical care nurses, entered an incredibly busy phase of their proud history repatriating injured personnel in their ICU in the air. On the ground, equipment was still essentially basic, particularly in Role 2 provision, with Tri-Service Apparatus and CompPAC Ventilator being the standard anaesthetic ‘machine’, although syringe drivers were entering service and enabling TIVA to be used on simple cases.

The subsequent conflict in Afghanistan led to the busiest times for DA, the largest Defence Medical Services (DMS) cadre, with ten years of intensive, challenging, but professionally rewarding work for both Regulars and Reservists in a totally Tri-Service environment with strong US and multinational collaboration. The multidisciplinary nature of the anaesthetist, with involvement at all stages of the patient pathway, could not have been more obvious, with research, dedication and innovation shaping trauma care at every stage. From point of wounding and transfer to the trauma centre (Baston) on the Medical Emergency Response Team helicopters, to the trauma teams, theatre staff, pain specialists, intensive care teams and medical director roles within Bastion and the CCAST repatriation teams, and beyond that, the homecare UK Role 4 teams, anaesthetists were there at every level, changing practice, acting as natural team leaders, upgrading equipment, providing world class research data and ... improving outcomes.

Defence Anaesthesia has been integral to major improvements in trauma care, including NHS-transferable lessons, and importantly has been at the forefront of passing on these skills in the form of the award-winning Military Operational Surgical Training Course and the pre-deployment courses known as HOSPEX, which have developed simulation training and a strong understanding of Human Factors. Family and professional disruption has been the norm, but huge support from NHS colleagues, the RCoA and AAGBI has been immensely appreciated.

Professionalism, quality, flexibility and teamwork have made DA the star in the DMS crown, and have highlighted anaesthetists’ abilities as natural team leaders and innovators, but recent events like Ebola and the rising threat from DAESH continue to test the system. Who knows what lurks around the corner but suffice it to say we have come a long way and learnt a lot in 25 years, and look forward to the challenge of the next 25 years.

Reference

See our RCoA ARIES Talk by Surgeon Captain Kate Prior on Lessons from the Battlefield via our YouTube Channel: http://bit.ly/2kbQtpa

Royal College of Anaesthetists
It's 6.00 pm, you're the on-call anaesthetist, and you're called urgently to a ward. On arrival, the patient is blue; they have a tracheostomy. Do you know what to do? Are you able to assess the tracheostomy? What are the people around you able to do? There are no ENT surgeons on site.

How do you resuscitate the patient?
Dr Philip Sherrard, Education Fellow, University College London Hospitals (UCLH)

Dr Abigail Whiteman, Consultant in Anaesthesia, University College London Hospitals (UCLH)

Dr David Walker, Consultant in Anaesthesia and Critical Care; Dr Robert Stephens, Consultant in Anaesthesia and Dr Gautam Kumar, Consultant in Anaesthesia, University College London Hospitals (UCLH)

The world wide web has revolutionised our life, and for those seeking knowledge, skills and an education there can be no better time to be learning. The ability to enter the school, take a seat at the front of the class and engage with a community of experts and peers, without leaving home and all at our fingertips, challenges everything we once thought learning may involve. As a consequence e-learning has infiltrated much of our professional lives.

The origins of e-learning can be traced back to Harvard-based psychologist Burhus Frederik Skinner, who in the 1950s developed a machine–delivered problem-solving device which administered carefully sequenced information to the learner. In the 1960s, an air-force based psychologist, Norman Crowder, improved upon this by incorporating feedback into the programme with a form of e-learning we still see used today. He used reinforced learning patterns with multiple choice questions. A correct answer opened a gateway to new learning material whereas an incorrect answer led to a reiteration of the original subject.1

It was not until the internet gained prominence in the 1990s that e-learning really took off. This new connectivity of smartphones and tablets it is no wonder that e-learning has become so successful.1 The size of the virtual classroom is potentially limitless, and this has led armies of adult learners to join internet communities for learning. A leading format in hasting these students is the MOOC.2

The Massive Open Online Course (MOOC) is exactly what it says on the tin: a course, free to users and with limitless numbers of student participants. The UCL Perioperative Medicine Group will launch a MOOC in the summer of 2017 offering an international audience the opportunity to learn about perioperative care.

References

THE RISE OF THE MASSIVE OPEN ONLINE COURSE (MOOC)

MOOCs are big international businesses, and there are multiple online providers such as Coursera, edX and Magni. The main UK provider is Futurelearn and can be accessed at www.futurelearn.com. Futurelearn is a subsidiary of the Open University, and generates income by offering optional paid certificates for some courses.2

Futurelearn launched their first MOOCs in September 2013, and have since registered close to 4.5 million users internationally. Subject-matter quality control comes by partnering with academic institutions. Futurelearn is now partnered with 62 universities and 32 specialist organisations covering a wide range of educational fields. Institutional badging comes with the assurance of high-quality materials, blended with a highly templated approach to course structure, lay out and pedagogy.

Medical journal publishers are getting involved in this market, and the British Medical Journal, for example, has launched two MOOCs since 2008 which explore the current best management of irritable bowel syndrome (http://bit.ly/2bJWfP) and the social determinants of health (http://bit.ly/2bJWfP).

For the student a MOOC involves learning through storytelling. The belief is that learning should be an enjoyable and social experience. A narrative woven throughout the course fosters engagement with learners to help this. An excellent example is a MOOC launched through University College London (UCL) called ‘The Many Faces of Dementia’. This highlights four less common diagnoses in dementia, and uses a patient’s journey to illustrate the learning outcomes. The methodology acknowledges the importance of the patient narrative to our acquisition of knowledge.1

The week-to-week activities include a range of different styles of learning and may involve film, reading articles, tests of knowledge and completing peer-assessed assignments. Each step is connected to the others, but is also designed for use independently. The steps are conveniently arranged into bite-sized chunks of learning typically 10 to 20 minutes in length, which may provide a convenient way for students to complete the assignment. This is aided by technological design elements that allow MOOC viewing on devices such as smartphones or tablets. The real appeal of the MOOC comes from the interaction in discussion with the thousands of other people across the world all studying together. The opportunity for international participation brings a wealth of different experiences and perspectives that may fill the gaps in our own knowledge.

The final draw is that the majority of MOOCs are completely free to study. So do log on to Futurelearn to explore the wide range of MOOCs available, and enjoy studying on a free, easy to use and highly convenient platform which draws on the experience of educators and students affiliated with some of the world’s top educational institutions.
THE CULTURE OF CARE WORKSHOPS IN WESSEX

(Part 2)

Dr Geoff Watson, Consultant in Anaesthetics and Intensive Care, Royal Hampshire County Hospital, Winchester

Dr Julia Parfitt, Anaesthetic Associate Specialist, Royal Hampshire County Hospital, Winchester

In Part 1, we discussed the issue of mutual support amongst doctors facing the daily stress of providing modern medicine. In this second part, we describe the approach we have taken in Wessex Deanery.

We have developed an innovative series of workshops working with Health Education Wessex, which are now being delivered to all trainee starters at induction days in the Deanery, as well as to a number of other professional groups in hospitals around Wessex.

Attendees are divided into small groups and given real stories to discuss amongst themselves, with a number of themes covered such as Death and Dying, Bullying, and Feedback and Debriefing. We use stories gathered from friends and colleagues, stories such as a maternal cardiac arrest; a sick relative undergoing surgery; a trainee humiliated in public, or objectives, a format that does not sit comfortably with a lot of people. However, our ambition is for the process to remind people of some of the reasons they chose to become a doctor in the first place; such as a long-held desire to help, to care or to provide a better way for people who are suffering. We hope that people will remember the reasons they entered the greatest profession there is; one that can take illness and from it create health, return life to people, and spread happiness out of the despair witnessed day by day. There is no attempt to teach or to change views, but rather an aim that attendees will leave with renewed energy and the confidence to make each day better, remembering that they themselves and their colleagues need care as well as their patients. Thus by the end of each session attendees will have gained some resilience to help with their day-to-day challenges, and know that they are not, and will never need to be, alone in caring!

Concerns that this may just be a ‘talking shop’ without proven benefit or measurable outcome continue to challenge the concept of the Culture of Care Workshops, but feedback over the past three years has been overwhelmingly positive. For example: ‘Possibly the best reflective session I have ever had – thank you’; ‘Nice to not have to sit and listen to a lecture – very thought provoking’; and ‘Difficult to improve this session as it was excellent!’

When asked what difference this will make or has already made to the day-to-day working experience, answers included: ‘Taking time to reflect and take myself out of stressful situations makes me a more effective doctor for the next patient’; ‘Remembering to do the little things breeds positivity – things such as making tea and discussing issues with the team’. The net result has been more efficient teams, less exhaustion, and a more productive day, with an improved likelihood of leaving work at a sensible time with all tasks completed. Sessions have been specifically provided at the request of the Deanery and employers to groups of doctors in difficulty, opening fresh lines of communication and leading to some resolution of problems as issues raised have been targeted by medical directors. This is valuable both at a personal and organisational level.

Having the experience of over 1000 attendees to draw on, we continue to develop new workshop themes, with such titles as ‘Pride and Ownership and Choices’. We are keen to share our success with other interested parties.

Further reading

Not a lecture, an interactive, mutually reflective event
Attendance at the workshops leads to a reappraisal of the sense of compassion and care that leads people into medicine. By creating a safe space in protected time, attendees are able to discuss emotive stories from personal experience with group support, so that individuals can care about themselves for a time. Our aim is not to instruct, but rather that attendees will leave with renewed energy, higher self-confidence and a plan to make each day more positive for themselves and their patients. Our ambition is for each person to make time to think more about themselves and those around them, so as to help each other attain their personal goals and to enable them to provide the highest possible standards of care for everyone – staff and patients alike.

Aims and objectives
We deliberately decided to set out each session without specific aims or objectives, a format that does not sit comfortably with a lot of people. However, our ambition is for the process to remind people of some of the reasons they chose to become a doctor in the first place; such as a long-held desire to help, to care or to provide a better way for people who are suffering. We hope that people will remember the reasons they entered the greatest profession there is; one that can take illness and from it create health, return life to people, and spread happiness out of the despair witnessed day by day. There is no attempt to teach or to change views, but rather an aim that attendees will leave with renewed energy and the confidence to make each day better, remembering that they themselves and their colleagues need care as well as their patients. Thus by the end of each session attendees will have gained some resilience to help with their day-to-day challenges, and know that they are not, and will never need to be, alone in caring!

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Further reading
ANAESTHETIC LEADS FOR SAFE PROCEDURAL SEDATION?

In the excitement of taking up my new consultant post, I (Seema Charters) accepted the challenge of becoming trust Sedation Lead. But how was I to go about it? Inspiration came from hearing Professor Rob Sneyd’s views, that clinicians in isolated areas need input from anaesthetists to develop safe procedural sedation practice.

A trust sedation committee existed, but meetings had stopped. My first challenge was to attract wide representation and restart meetings. Each area had differing requirements, with no uniformity in staffing levels or training. Anaesthetists, many of whom deliver comparatively little sedation in practice, have defined training competencies published by the RCoA, yet there was nothing for Allied Health Professionals. The Sedation Committee’s first task was to arrange compliance with the National Reporting and Learning Service’s report on reducing the risk of overdose with midazolam.2 A trust sedation committee existed, with interventional radiology, interventional cardiology, imaging and orthopaedic departments. A mixture of lectures, debate, and group discussions was arranged. Lectures began with my original inspiration, Professor Sneyd, as keynote speaker. He had recently chaired the Academy of Medical Royal Colleges’ working party on Safe Sedation Practice for Healthcare Procedures,4 which defines fundamental standards for who gives sedation, where, and how. Quoting the NAP5 Audit Project3 he stressed the importance of well-informed consent for sedation, with the patient not expecting sleep or lack-of-awareness. Emphasis was placed on the use of capnography as a monitoring standard.

Lectures by the internal faculty of anaesthetists, intensivists, a radiologist and a gastroenterologist followed, covering the basics of assessment, pharmacology, monitoring and adverse events. Our next challenge arrived with the introduction of propofol. Gavin Lloyd’s podcasts and publications on procedural sedation in the ED made him an obvious choice as speaker. His wide experience and confident, safe use of propofol in the ED, prompted the debate on ‘Use of Propofol by non-anaesthetists’. Recent celebrity deaths from sedation in the presence of a doctor were used to highlight the need for appropriate training and competence. Ultimately, few anaesthetists were persuaded that non-anaesthetists should administer propofol.

The day ended with delegates involved in group discussions and interactive scenarios, to consider many different facets of sedation.

While designing a short course manual I found many internet-based learning resources, and a lot was provided to course participants. The Royal College of Emergency Medicine learning resources5 is recommended. Feedback for this novel course was overwhelmingly positive. We have noted a change in sedation practice, from diazepam to midazolam, in our orthopaedic department. Simulations based on procedural sedation are now used in clinical areas. Our senior ODPs are keen on becoming sedationists. Our next step is to establish a trust-wide competency framework for sedation.

Overall, this has been a challenging yet enjoyable venture. Anaesthetists should embrace the role of Sedation Lead. From our experience, there is interest, and anaesthetists are best placed to support others to improve patient safety.

References
A new award was launched for the 25th Anniversary year to celebrate excellent training in anaesthesia, critical care and pain medicine. Anaesthesia Trainee Representative Group (ATRG) members were invited with local trainees to nominate up to three local trainers for an award.

Our aim was to recognise trainers who:

- have a willingness and ability to share skills, knowledge and expertise
- have an enthusiastic and positive attitude
- promote lifelong learning in trainees and others
- provide constructive feedback and guidance
- motivate all around them by setting a good example
- listen to and value the opinions of trainees
- have the respect of colleagues and others throughout the organisation.

The following trainers have been successful in receiving the RCoA Trainer Award and have received a certificate (names are listed by Schools of Anaesthesia).

**Barts and the London**
- Dr Lionel Davis – The Royal London and Homerton Hospital
- Dr Sumitra Lahiri – The Royal London Hospital

**Birmingham**
- Dr Alejandro Barrios – University Hospitals Birmingham
- Dr Carl Stevenson – The Dudley Group of Hospitals NHS Trust
- Dr Mark Tindall – The Dudley Group of Hospitals NHS Trust

**Bristol**
- Dr Sarah Bakers – Gloucestershire Royal Hospital
- Dr Patrick Morgan – Southmead Hospital
- Dr Benjamin Walton – Southmead Hospital

**Central London**
- Dr Catherine Shaw – Whittington Hospital

**East of England**
- Dr Elizabeth Bright – West Suffolk Hospital
- Dr James Simpson – Queen Elizabeth Hospital
- Dr Jane Sturgess – Bury St Edmunds Hospital

**Imperial**
- Dr Michelle Hayes – Chelsea and Westminster Hospital
- Dr Kausalya Rao – Northwick Park Hospital

**Kent, Surrey, Sussex**
- Dr James Cooper – Royal Sussex County Hospital
- Dr Claire Mearns – East Surrey Hospital
- Dr Kyne Woodford – Royal Sussex County Hospital

**Mersey**
- Dr Mruga Diwan – The Royal Liverpool and Broadgreen Hospital Trust
- Dr Lawrence McCrossan – Royal Liverpool University Hospital
- Dr Yick Meng Andrew Wong – St Helens and Knowsley NHS FT

**North of Scotland**
- Dr Kathleen Ferguson – Aberdeen Royal Infirmary
- Dr Graham Johnston – Aberdeen Royal Infirmary
- Dr Colin Patterson – Aberdeen Royal Infirmary

**North West**
- Dr Geraint Briggs – University Hospital of South Manchester
- Dr Elizabeth Thomas – Stepping Hill Hospital
- Dr Christopher Stoll – Royal Lancaster Infirmary

**Northern**
- Dr Siew Tuck Stephen Chay – James Cook University Hospital
- Dr Jeremy Andrew Evans – Royal Victoria Infirmary
- Dr Nicholas Julian Kennedy – University Hospital of North Durham

**Nottingham and East Midlands**
- Dr Jonathan Davies – Nottingham City Hospital
- Dr Michael Gareth Moncaster – King’s Mill Hospital

**Oxford**
- Dr Justin Mandeville – Buckinghamshire Hospitals
- Dr Carl Morris – Buckinghamshire Hospitals
- Dr Matthew Size – Buckinghamshire Hospitals
Anaesthesia Research Innovation Education and Scientific (ARIES) Talks
Free, short, informative and entertaining talks from high profile speakers on areas of relevance to anaesthesia, critical care and pain medicine.

1 June 2017
Anaesthesia and space, pain, ebola, teamwork, safety and more

10 July 2017
Everest 10 years on, organ donation and more

For full details and to book a place, please visit www.rcoa.ac.uk/rcoa25

Visit our YouTube channel to see our ARIES Talks online
LIFE-LONG LEARNING – NEW TECHNOLOGY VISION

As work progresses to develop a new e-Portfolio, staff and members reflect on what this will mean for Trainees, Trainers and the College.

Russell Ampofo, RCoA Director of Education, Training and Examinations

The new RCoA Strategy and organisational structure brings education, training and examinations together under one directorate to harmonise the College’s offer and operations, and to better support and develop anaesthetists, whatever their grade, whatever their location and whatever their clinical or non-clinical interests might be.

The Strategy presents a clear mandate and opportunity for the College to develop a portfolio system that doesn’t just support trainees in logging training information online, but also provides an interactive and seamless platform that will support anaesthetists throughout their career. Our long-term aspiration is that, following a single log-in, our members will be able to access an integrated portfolio, logbook, CPD and learning platforms in the same area.

We will be speaking directly to you as Members, Fellows and other users of the system about what functionality you would like to see in our new systems, and how you will use them in the workplace, on the move, and for furthering your careers.

Dr Karen Pearson, Trainee Anaesthetist, Dundee

As the elected trainee-member of the RCoA Scottish Advisory Board, I participated in a number of workshops last year assessing the current state of the e-portfolio. These were thought-provoking and explored actual user practicalities, trainee and trainer interactions, pitfalls with the current system and opportunities and ideas for future improvements. I am excited by the idea of continuing this involvement in the creation of this new platform. I believe that trainee engagement in this process is absolutely key to creating a truly functional, integrated and future-proofed e-portfolio system to fulfill our needs.

Dr Ian Whitehead, Consultant Anaesthetist, South Tees

As a member of the e-Portfolio User Group and now as Chairman of the Joint Assessment and e-Portfolio Committee, I can confirm that we have tried, based on user feedback, to improve the current trainee e-portfolio over several years. The new trainee e-portfolio – part of the RCoA Lifelong Learning Portfolio – is an exciting opportunity, which will allow us to get it to work in a way that users want. We are currently in the process of selecting a new technology partner to work with, and I look forward to working with them in the design and development stages. Watch out for further information, as there will be change to come later in the year!

Dr JP Lomas, Consultant Anaesthetist, Greater Manchester and RCoA Member of Council

In 2017, nearly three years after the idea of putting College resources into making IT better for all Fellows and Members, I’m delighted that the Lifelong Learning Portfolio is gaining traction. The experience of watching a vision gradually taking shape is truly fantastic, and I hope that we can provide a solid and sustainable IT foundation for all anaesthetists.

Dr Jamie Strachan, RCoA Technology Strategy Programme Fellow, Oxford University Hospitals

I’m excited about improving the experience for trainees and trainers alike. We are doing this by starting with the question ‘how do we want to work, teach and learn?’, and then fitting a solution to the answers. Many of you have attended workshops and offered help with the project, and lots of you have been in touch by email to pass on thoughts – that’s been really helpful so far – keep it up! Email us at tsp@rcoa.ac.uk or find more information at www.rcoa.ac.uk/tsp.
ELECTION TO COUNCIL 2017 – MEET THE NEW MEMBERS

I am pleased to announce the election of Consultants Professor Judith Hall, Dr Chris Carey, Dr Russell Perkins and Trainee Representative Dr Jenny Cheung to Council of the Royal College of Anaesthetists.

Many thanks to the 15 candidates for standing, and the 32% of Consultants and 33.3% of Trainees who voted. Terms of office commence in March 2017.

Voting for election to Council closed on Monday, 5 December 2016 and the ballot process was independent and managed by Electoral Reform Services.

Full election results can be found online: http://bit.ly/2kyLZZW.

‘Congratulations to all those successfully elected – I look forward to working with them.

After what has been a difficult 12 months for healthcare, it is great to see so many candidates and a high turnout. I am pleased that we continue to have an engaged membership who are the foundation of the College.’

Dr Liam Brennan, President

Professor Judith Hall

I am a trauma anaesthetist, a Final FRCA Examiner and a Professor of Anaesthetics. What I bring to Council is a depth of experience in successfully developing and managing major projects, teams and budgets. I like to think I am an innovator. I hold patents, develop devices, innovate in research, education and processes. Certainly, we must think differently to improve for our patients and the NHS.

I believe global partnerships can benefit all. Many Anaesthetists found Brexit disheartening, but now we must look increasingly beyond our borders. British anaesthesia has clinical excellence and a safety culture to be proud of, but we can improve further. This can be done by looking outwards, sharing and learning. I have collaborated extensively with low- and middle-income country partners in Africa, and with the USA and Europe: they have much to teach us. While exporting our brand of excellence, we will inevitably become better ourselves.

Dr Chris Carey

I qualified from St Mary’s in 1995 and subsequently trained in north west London, where I was greatly influenced by many of the trainers that I encountered. I was appointed as a consultant at Brighton and Sussex University Hospitals in 2004 where I specialise in neuroanaesthesia.

I was College Tutor for Brighton and Sussex University Hospitals NHS Trust from 2007–2010 and then spent six years as Head of the KSS School of Anaesthesia. Since 2016 I have been an Associate Postgraduate Dean in HEE KSS and I also lead the MSc in anaesthesia and perioperative medicine at Brighton and Sussex Medical School.

I have worked with the College on the perioperative medicine programme and chair the undergraduate anaesthesia training group.

My wife, Fleur, is a preoperative assessment nurse and we have two sons who are currently at school.

Dr Russell Perkins

I was born in the South East of England but spent my formative years in the North West being educated just outside of Liverpool. I returned to London for my medical education but settled in the North West for my consultant’s post at Booth Hall Children’s Hospital with interests in burns and plastics, trauma and orthopaedics. I now work at the Royal Manchester Children’s Hospital.

I have been College Tutor, Deputy Regional Adviser and Regional Adviser as well as an FRCA Examiner. I have an interest in education both of anaesthetists but also medics in general through the Advanced Paediatric Life Support (APLS). My most recent projects include setting up an MSc in paediatric anaesthesia and neuroanaesthesia, and will be undertaking an O&PE in neuroanaesthesia at St George’s Hospital from August 2017. Jenny was previously a member of the BMA’s national Junior Doctors’ Committee from 2013–2015, and was on their Executive Subcommittee from 2012–2013. She was a co-opted member of the AAGBI’s GAT committee from 2013–2014. Outside of medicine, Jenny is involved in her local church, playing violin in the band and string quartet, welcoming international students and helping them to improve their English language skills.

Dr Jenny Cheung

Jenny Cheung graduated from Imperial College London in 2009, and subsequently completed her foundation years in the South Thames Foundation School. Her core anaesthetic training was in south-west London, after which she became a higher trainee in the Kent, Surrey, and Sussex school of anaesthesia. She is currently completing her ST6 year at Guy’s, St Thomas’ and the Evelina London Children’s hospitals. Jenny intends to subspecialise in paediatric and neuroanaesthesia, and will be undertaking an O&PE in neuroanaesthesia at St George’s Hospital from August 2017. Jenny was previously a member of the BMA’s national Junior Doctors’ Committee from 2013–2015, and was on their Executive Subcommittee from 2012–2013. She was a co-opted member of the AAGBI’s GAT committee from 2013–2014. Outside of medicine, Jenny is involved in her local church, playing violin in the band and string quartet, welcoming international students and helping them to improve their English language skills.

Meet the New Members

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REPORT OF MEETINGS OF COUNCIL

At a meeting of Council held on Wednesday, 14 December 2016 the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

Regional Advisers
Kent, Surrey, Sussex
Dr S Sudan (Royal Sussex County Hospital, Brighton) in succession to Dr S Panayiotou

Deputy Regional Advisers
Wales
Dr S Ford (Morriston Hospital, Swansea) in succession to Dr T McEldad

West Midlands
Dr H Funnel in succession to Dr T McEldad

College Tutors
West Yorkshire
Dr H Schlenburg (Dewsbury District Hospital) in succession to Dr S B Walwyn

North Thames Central
Dr D Sollanfar (Royal Free Hospital) in succession to Dr R Simons

North West
*Dr R Merley (Royal Manchester Children's Hospital)

Wessex
Dr C Joannides (Dorset County Hospital) in succession to Dr J Hull

South Thames East
*Dr O Rose (University Hospital Lewisham)

Certificate of Completion of Training
To note recommendations made to the GMC for approval, that CCTs/CESRs (CPs) be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in Anaesthesia, or Anaesthesia with Intensive Care Medicine or Pre-Hospital Emergency Medicine where highlighted.

Anglia
Dr Andrew Conway-Morris (Joint ICM)

Leicester
Dr Elinor Wighton

London
Dr Suman Biswas
Dr Adam Duffen
Dr Rajesh Sinistava
Dr Catherine Carlin (Dual ICM)
Dr Danielle Costello (Joint ICM)

North Central
Dr Anthony Gubbay
Dr Oliver Petroni

Barts and The London
Dr Chineag Tolati
Dr Sophie Liu

South East
Dr Nicholas White

St George’s
Dr Remy Mattakea

Northern
Dr Emily Bonner
Dr Neil Hall

Oxford
Dr Katharine Francis
Dr Luis Lee

Scotland
Dr Lornane Hanttington

West of Scotland
Dr Katharine Livingstone
Dr Michael McLaughlin

South West Peninsula
Dr Kathryn Howell
Dr Sam Andrews

Wales
Dr Kathryn Lloyd-Thomas

Wessex
Dr Alice Aarvold
Dr Sonya Daniel (Joint ICM)

West Midlands
Dr Zehrin Nassa
Dr Emma Plunkett

Stoke
Dr Linga Prasad

Yorkshire and Humber
Dr Chloe Fairbairns

South
Dr Nicola Pawley (Joint ICM)
Dr Chi Ng
Dr Rashmi Senaratne

Fellows by Examination
Council received and approved the list of Fellows by Examination who were successful at the December Final FRCA SOE Examination:

Aggarwal Seetal Kaur
Ali Khayak O’Leary Cara Dannielle
Allen Wei-Lin
Amare Mustaz Muhamed Ziaam A
Anderson Catherine Mary
Anwar Asaker Ahsad
Arildge James William
Awolument Ogugberi Benjamin
Baba Foyaz Ahmad
Baker Timothy David
Balakrishnan Subhadra Devi
Barnett Gillan
Bayoumi Mohamed Naeem Mohamed Ahmed
Beckett Samuel John
Bell Alexander Graham
Benthall Suzanne Kassem
Benson Richard Paul
Benton Antonia Clare
Bhagwat Amrit
Bhat Sunny
Bhimie Karen Ann
Blagnys Hannah Lesley
Bopitiya Palitha Bopitiya Gamaehtige Lakshman
Bowen Jessica Lynne
Brain Neil James
Braziel Nicholas Robert
Brougham Thomas Oliver
Brown Wendy Sarah
Brownie Katherine Fitzgerald
Bubb Laura Patricia
Buswell Victoria Rose
Byars John-Patrick
Carey Benjamin Matthew
Carter Paul Andrew
Cashman Josephine Byrne
Chambers Owen Jonathan
Charlesworth Michael
Chaudhury Muhammad Nadir
Cherin Lin
Chow Gary Chung Lim
Clark Natalie
Clyburn Rhys
Coates James Christopher
Cossey Louise May
Creed Matthew Jan
Cross Charles William
Dalton Mark James
Daniels Christine Pasadzhi
Darling Rachel Lindsay
De Silva Seneetha Tharsha
De Vena Francs Pablo Leonardo
Dean Charlotte Bernas
Devine Matthew John
Doyle Alexander John
Edwards Adam Gregory
El Damatty Essam Ahmad Abbas El Damatty
Elliott Louise
Elliott Serena Kirsten
Emmett Lucy Jane
England Emma Louise
English Leonie
Fadden Emma Jane
Finlay Claire
Fitmaucourn Bethany Clare
Freshwater Isabel Lilan
Garcia Mark
Gwanwood Brett Elizabeth
Ghabina Sheriff
Gibbins Matthew Llewelyn
Gibson Kyle
Gibson Jane Louise
Gopinath Aiyth
Gouldson Sarah Louise
Gravel Neville Gena
Greenshields Nicola Pamela
Grimes Lisa Anne
Groves Paul Charles
Guha Abhik
Hadi Dina H
Hakim Carla

Hall Neil Owen
Hares Jennifer Clare
Hargreaves Thomas
Haroon-Mohamed Yunna
Harper Samuel Luke
Harvey Eleanor Mhari
Hawkins Richard Anthony
Helferan Hayley Danielle
Heikal Sarah
Hester Natalie Amber
Hetherington Jonathan James
Hews Justin David
Hickey Stephen
Hoare Nicholas Jonathan
Hogan Nicola Joy
Hollis Chaim Shorath
Hoque Nazima Begum
Howell Malcolm Douglas
Hoy Michael Andrew
Hughes Duncan Stuart
Hurry Alastair William David
Ikponmwoosa Bethany Jane
Irwin Rachel Sarah Helen
Jagelman Timothy Alexander James
James Kathryn Elizabeth
James Michael Edward
Javed Muhammad Anser
Jans Martyn Barry
Jones Kathryn Elizabeth
Kelly Kevin Paul James
Kelly Donna
Kennedy Natasha Ann
Keshkamat Ashwini Umakant
Khan Ayub
Kohler Katharina
Kola Benjamin Michael
Kuzhivelie Julie Elizabeth
Lau Nor Lan
Lay Frances Elizabeth
Leong Mehnul Yahya
Lochner Christopher
MacKay David Lachlan
Maher Wael Samir Mohamed Amin
Maini Naveen

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At a meeting of Council held on Wednesday, 11 January 2017 the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

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

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

**College Tutors**

**West of Scotland**
- Dr. C. Guha, Monklands Hospital
- Dr. C. A. Storach, Wishaw General Hospital
- Dr. C. L. Harper, Queen Elizabeth University Hospital

**North East**

**North**
- Dr. J. Thimappa (Darlington Memorial Hospital) in succession to Dr. R. J. Geary
- Dr. J. B. O’Neal (University Hospital of North Durham) in succession to Dr. A. Holohan

**North East**

**Northern**
- Dr. T. P. Ford (University Hospital of North Durham) in succession to Dr. R. J. Geary
- Dr. J. B. O’Neal (University Hospital of North Durham) in succession to Dr. A. Holohan

**South East**

**South East**
- Dr. A. T. Johnson (University Hospital of North Durham) in succession to Dr. R. J. Geary

**South West**

**South West Peninsula**
- Dr. R. J. Geary (University Hospital of North Durham) in succession to Dr. A. Holohan
- Dr. T. P. Ford (University Hospital of North Durham) in succession to Dr. R. J. Geary

**West Midlands**

**Birmingham**
- Dr. R. J. Geary (University Hospital of North Durham) in succession to Dr. A. Holohan
- Dr. T. P. Ford (University Hospital of North Durham) in succession to Dr. R. J. Geary

**Yorkshire and Humber**

**East**
- Dr. J. B. O’Neal (University Hospital of North Durham) in succession to Dr. R. J. Geary
- Dr. T. P. Ford (University Hospital of North Durham) in succession to Dr. R. J. Geary

**South**
- Dr. A. T. Johnson (University Hospital of North Durham) in succession to Dr. R. J. Geary
- Dr. T. P. Ford (University Hospital of North Durham) in succession to Dr. R. J. Geary

**Certificate of Completion of Training**
To note recommendations made to the GMC for approval, that CCTs/CESR (CPs) be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in Anaesthesia, or Anaesthesia with intensive Care Medicine or Pre-Hospital Emergency Medicine where highlighted.

**Anglia**
- Dr. D. Bamford
- Dr. P. Dewar
- Dr. P. Kamath

**London**
- Dr. N. Nicholas
- Dr. K. Sherratt
- Dr. M. Gilhoody
- Dr. S. Iqbal

**South East**
- Dr. S. Yamoll
- Dr. S. Black
- Dr. P. Dewan
- Dr. P. Kamath

**Yorkshire and Humber**
- Dr. J. B. O’Neal (University Hospital of North Durham) in succession to Dr. R. J. Geary
- Dr. T. P. Ford (University Hospital of North Durham) in succession to Dr. R. J. Geary

**Scotland**

**North of Scotland**
- Dr. A. T. Johnson (University Hospital of North Durham) in succession to Dr. R. J. Geary
- Dr. T. P. Ford (University Hospital of North Durham) in succession to Dr. R. J. Geary

**West of Scotland**
- Dr. A. T. Johnson (University Hospital of North Durham) in succession to Dr. R. J. Geary
- Dr. T. P. Ford (University Hospital of North Durham) in succession to Dr. R. J. Geary

**Certificate of Eligibility for Specialist Registration (CESR)**
To note recommendations approved by the GMC, that a CESR be awarded to those set out below:
- Dr. M. Same
- Dr. S. Sanyal
Having at that time (1899) worked for about a dozen years with esophagoscopy, and for five years with Kirstein’s direct laryngoscopy, I took hold of bronchoscopy with enthusiasm.

Dr David Zuck, History of Anaesthesia Society

The construction of a practical bronchoscope, the development of a technique for its safe passage, and the proving of the harmlessness of its careful use were but initial steps. They were fundamental, of course, but to accomplish anything more than mere inspection hundreds of accessory instruments and techniques for their respective uses must be developed. Pitfalls and dangers in each new development must be eliminated. To do untried things on a baby, so tender in his tissues, so helpless, so defenseless, was unthinkable. Some methodical plan must be developed and followed in testing each step of each procedure before using it on a baby. Baby cadavers could be used for the purely anatomical studies; but for the solution of mechanical problems – that is, the manipulation of foreign bodies so as to extricate them from the bronchi without injury to the tissues – work in living, moving bronchi was necessary. For this the dog was the recourse.

No one could have a greater fondness for dogs than I have, and it was a sore trial for me when in the prior development of esophagoscopy I did my first endoscopy on a dog. To my great relief I found that the dog could be perfectly narcotized so as to feel nothing, to know nothing, yet come out of the narcosis unharmed, happy, and hungry. Moreover, the dog was not subjected to any procedure until after it had been fully tested and perfected by work with a bronchoscope down in a rubber tube so arranged as to simulate a bronchus. If the procedure was found practicable in the rubber-tube manikin it was next tested on the cadaver. If it proved satisfactory, the test on the dog was undertaken. Any bronchoscopic procedure to be justifiable must be workable entirely within the bronchial lumen without trauma to the normal walls. In the many tests of mechanical problems of foreign body extraction from bronchi one dog died; nor was one injured. On the other hand incalculable thousands of babies’ lives were saved, and will be, by the procedures developed.

The work involved in carrying out all these preliminary details was tremendous. A procedure requiring only a few minutes on the patient required many days, sometimes even weeks, of preliminary work. Being purely mechanical, the problem must be soluble, was the motto. And so it was proved to be by the more than 98 per cent of successes, on human beings, mostly children.

All of this system of working had been developed with the esophagoscope. It remained, however, to adapt methods to the anatomically and physiologically different passages. The esophagus is a soft, elastic, collapsed, bag-like tube full of wrinkles and folds; the tracheobronchial tree stands open by reason of its rings of cartilage. The bronchi enlarge and elongate at each inspiration, diminish and shorten during expiration. The heart at each beat dinges in the bronchial wall or pushes the whole bronchial tube sideways; the thumping is transmitted to the fingers holding the inserted bronchoscope. One gets the impression of being in the midst of the machinery of life itself. In a baby the obvious delicacy of life’s constantly moving machinery is appalling. To work in such surroundings through a tube not much larger than a straw to manipulate a safety pin, for example, is daunting to the utmost degree. Fully to comprehend this, it must be realized that ‘safety’ of such pins applies only to location in clothing and even then only when closed. In the bronchi they are usually open, the sharp point is upward and being forced by the spring into the bronchial wall. Moreover that delicate wall is beset with catchy ridges.

Dr David Zuck sadly passed away in November 2016. This will be his last article for the Bulletin.
CONSULTATIONS

The following is a list of consultations which the RCoA has responded to in the last two months. Those published on the RCoA website via our Responses to Consultations area (http://bit.ly/2kz1uB3) are marked with an asterisk.

<table>
<thead>
<tr>
<th>Originator</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Institute for Health and Care Excellence/NHS England</td>
<td>Joint NICE and NHS England consultation on changes to the Technology Appraisals and Highly Specialised Technologies programmes</td>
</tr>
<tr>
<td>NHS England</td>
<td>Action to reduce sales of sugar-sweetened drinks on NHS premises*</td>
</tr>
<tr>
<td>NHS England</td>
<td>The multispecialty community provided (MCP) emerging care model and contract framework*</td>
</tr>
<tr>
<td>Association of Anaesthetists of Great Britain and Ireland</td>
<td>Best practice for total intravenous anaesthesia guideline</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Work, health and disability: improving lives</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>Hip fracture management: Addendum consultation</td>
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<tr>
<td>Care Quality Commission</td>
<td>Our next phase of regulation – A more targeted, responsive and collaborative approach</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>Medical technology consultation alert: SecurAcath for securing percutaneous catheters</td>
</tr>
</tbody>
</table>

DEATHS

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

- Dr Anthony Bryan Telford
- Dr Mark Churcher Devon
- Dr Francois Dosangue Bunwood, Australia
- Dr Swati Karmarkar Stockport
- Dr Roddie McNicol Glasgow
- Professor Johannes Meyer Germany
- Dr Frederic Plumptre West Sussex
- Dr Kuldip Rai London
- Dr Jaspreet Singhote Bedford
- Dr Elizabeth Sizer London

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 Despoina Saridou
- Dr Irena Greco
- Dr E Masoni

Member
- Dr Barrie Phillip Robertson

Associate Members
- Dr Clare Mary Ellen Smyth
- Dr Carlo Gravina
- Dr Neil Christopher Cattell

APPPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

The College congratulates the following Fellows on their consultant appointments:

- Dr Jonathan Aron
  St George’s Hospital, London
- Dr Katie Ayashe
  York Teaching Hospitals NHS Foundation Trust
- Dr Reema Ayashe
  James Cook University Hospital
- Dr Abhijoy Chakladar
  Brighton and Sussex Hospitals NHS Trust
- Dr Vijayendra Chikkabbaiah
  Nottingham University Hospital
- Dr Katrina Dick
  University Hospital, Ayr
- Dr John Harris
  Leighton Hospital, Crewe
- Dr David Hunt
  Frimley Park Hospital Foundation Trust, Surrey
- Dr Zehrin Nassa
  Royal Orthopaedic Hospital, Birmingham
- Dr Karen Orr
  Royal Victoria Hospital, Belfast
- Dr Arvinder Singh
  Salford Royal NHS Foundation Trust
- Dr Matthew Stegg
  Blackpool Victoria Hospital
- Dr Catherine Vass
  Monklands Hospital, North Lanarkshire
- Dr Elinor Wighton
  Leicester Royal Infirmary

Apologies to Dr Janine Talbot for incorrectly listing her appointment in the January issue. Dr Talbot has been appointed as a Consultant Anaesthetist at Southmead Hospital, Bristol.

2017 ANNUAL GENERAL MEETING

The 2017 Annual General Meeting of the Royal College of Anaesthetists will be held as follows:

Thursday, 9 March 2017 at 10.50 am
Mermaid Conference and Events Centre, Puddle Dock, Blackfriars, London EC4Y 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.

ELECTION TO THE RCoA ADVISORY BOARD FOR SCOTLAND 2017 RESULTS

Voting for vacancies to the RCoA Board for Scotland closed on 12 January 2017 at 5.00 pm.

Consultant Vacancy

I am pleased to announce that Dr William McClymont of Ninewells Hospital in Dundee was elected and joins the board from March 2017.

Many thanks to the three candidates for standing and the 39.4% of Fellows who voted.

The full results can be found here: http://bit.ly/2iDYxQD.

The ballot process was managed on behalf of the College by Simply Voting.

SAS Vacancy

I am also pleased to announce that Dr Graeme Brannan of University Hospital Crosshouse in Kilmarnock has been appointed to the board’s SAS vacancy unopposed.

More details about the work of the RCoA Board for Scotland can be found here: www.rcoa.ac.uk/scotland.

Tom Grinyer
Chief Executive Officer
Save the date for the second National Institute of Academic Anaesthesia (NIAA) Annual Scientific Meeting, taking place at the RCoA on Friday, 12 May 2017. This meeting is an opportunity to hear about a range of NIAA-related research activities, including the Health Services Research Centre (HSRC) and ‘big data’ agenda. There will also be an update on the work of the UK Perioperative Medicine Clinical Trials Network one year after its launch, and a session on anaesthesia within the NIHR Clinical Research Network portfolio.

To book your place to attend please visit the Event booking page (http://bit.ly/NIAA-ASM).

NIAA RESEARCH AWARD 2017

The Scientific Meeting also includes the NIAA Research Award, which is open to all research active investigators of anaesthesia, critical care, perioperative medicine and pain within the UK who are engaged in a higher degree programme. Applicants for the award should submit an abstract based on a clear, evidence-based research question, and shortlisted applicants will be invited to present at the meeting.

For more information on how to apply for the Research Award including criteria, please visit: http://bit.ly/NIAA-Award.

Deadline for Research Award applications is Monday, 13 March 2017.

Courses for the Royal College of Anaesthetists Examinations

<table>
<thead>
<tr>
<th>Courses</th>
<th>Dates 2017/2018</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary SBA/MCQ</td>
<td>21-27 July</td>
<td>October 2017</td>
</tr>
<tr>
<td>Primary OSCE Weekend</td>
<td>21-23 April</td>
<td>October 2017</td>
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<tr>
<td>Primary Viva Weekend</td>
<td>28-30 April</td>
<td>October 2017</td>
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<tr>
<td>Primary OSCE/Orals</td>
<td>5-12 May</td>
<td>October 2017</td>
</tr>
<tr>
<td>Final SBA/MCQ</td>
<td>11-17 August</td>
<td>February 2018</td>
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<tr>
<td>Final SAQ Weekend</td>
<td>18-20 August</td>
<td>February 2018</td>
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<tr>
<td>Final Written ‘Booker’</td>
<td>20-25 August</td>
<td>February 2018</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>

1 attended the week long OSCE/Orals course. It was a long and intense week but I am so glad that I signed up. It was great to meet other colleagues in the same situation who have also been preparing hard for the last few months. Aside from the invaluable frequent exposure to exam conditions, I believe what sets the MSA course apart is the mindset which it equips you with to approach the exam. – Primary OSCE/SOE Candidate November 2016

The Mersey Course itself was intensive, tough and tiring but I can’t think of any better preparation. Apart from generic book work, I pretty much just did the framework again and again before I went up. The Course gave me all the exposure, technique and confidence I needed! – Primary OSCE/SOE Candidate November 2016

I attended the week long OSCE/Orals course. It was a long and intense week but I am so glad that I signed up. It was great to meet other colleagues in the same situation who have also been preparing hard for the last few months. Aside from the invaluable frequent exposure to exam conditions, I believe what sets the MSA course apart is the mindset which it equips you with to approach the exam. – Primary OSCE/SOE Candidate November 2016

I had worked hard in the lead up to the exams having started in March and passing the MCQ in September this gave me six weeks to get OSCE / Viva ready. The first thing I would say to candidates attending the Mersey is about the importance of preparation. The purpose of the Mersey isn’t to teach you everything you need to know to pass, it is to develop the skills to be able to utilise all the knowledge you have under pressure on the day and shine! I had revised with a colleague from work who in my opinion had a MUCH greater amount of knowledge, a deeper understanding and I thought would sail through the exam. He didn’t attend the Mersey and I was shocked to hear after his exam that he had failed. The only reason I can see for this is not that he didn’t know the answers but having not been to the Mersey he lacked those Key Performance Skills that I had gained from the Mersey course - it is these that will make the difference between a pass and a fail whether you can reproduce the bioavailability of carbamazepine or be able to draw the structure of ketamine.

I cannot thank all the staff at the Mersey enough. They helped me help myself to pass, and now I have my life back! – Primary OSCE/SOE Candidate November 2015

To see details of all our courses please visit: www.msoa.org.uk or contact us at: enquiries@msoa.org.uk
Our Continuing Professional Development (CPD) Days are designed for busy doctors, to efficiently maintain competence and aid with revalidation in anaesthetic and surgical practice.

These study days will provide updates on new treatments and techniques, including top tips on improving your performance, from specialists in the clinical field. You will also have access to experts who will equip you with new skills to cope better with the demands of everyday working life.

**CPD Study Days**

- **30–31 May 2017**
  - [#RCoACPD](https://twitter.com/search?q=#RCoACPD&src=typd)
MARCH

8–9 MARCH 2017
RCoA 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

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

30 MARCH 2017
Joint RCoA/RSM Meeting: Anaesthesia and Surgery: The Interface
RSM, London
Please see RSM website for fees
http://bit.ly/2kp1zd

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

26 APRIL 2017
GASAgain [Giving Anaesthesia Safely Again] Return to Work Simulation Course
RCoA, London
£200 (£150 for RCoA registered trainees)

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

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)

8 MAY 2017
Joint Clinical Directors Meeting with the AAGBI
RCoA, London
BY INVITATION ONLY

9–10 MAY 2017
Cardiac Disease and Anaesthesia Symposium
RCoA, London
£395 (£315 for RCoA registered trainees)

11 MAY 2017
Ethics and Law for Anaesthetists
RCoA, London
£200 (£150 for RCoA registered trainees)

12 MAY 2017
NIAA Annual Scientific Meeting
RCoA, London
£45

17–18 MAY 2017
Updates in Anaesthesia, Critical Care and Pain Management
Caledonian University, Glasgow
£355 (£270 for RCoA registered trainees)

22 MAY 2017
Joint RCoA/RCEM Major Trauma Study Day
RCoA, London
£200 (£150 for RCoA registered trainees)

23–24 MAY 2017
Introduction to Leadership and Management: The Essentials
RCoA, London
£395

30–31 MAY 2017
CPD Study Days
RCoA, London
£355 (£270 for RCoA registered trainees)

JUNE

1 JUNE 2017
ARIES Talks
RCoA, London
Free

5 JUNE 2017
Anaesthetists as Educators: An Introduction
RCoA, London
£220 (£165 for RCoA registered trainees)

8 JUNE 2017
BJA, NIAA and Cochrane ACE Systematic Review and Meta-analysis Workshop
RCoA, London
£150

12–13 JUNE 2017
UK Training in Emergency Airway Management (TEAM) Course
Solihull Hospital, Birmingham
£450

13–14 JUNE 2017
Summer Symposium – Providing High Quality Anaesthetic Care in a Sustainable Healthcare System
The Waterfront Hall, Belfast
£395 (£295 for RCoA registered trainees)

15–16 JUNE 2017
College Tutors Meeting
The Waterfront Hall, Belfast
BY INVITATION ONLY

26–27 JUNE 2017
UK Training In Emergency Airway Management (TEAM) Course
Royal United Hospital, Bath
£450

27 JUNE 2017
GASAgain (Giving Anaesthesia Safely Again) Return to Work Simulation Course
Royal Bournemouth Hospital
£240

28 JUNE 2017
Airway Workshop
RCoA, London
£240 (£180 for RCoA registered trainees)

3–7 JULY 2017
Final FRCA Revision Course
RCoA, London
£395

14 JULY 2017
Patient Safety in Perioperative Practice
RCoA, London
£200 (£150 for RCoA registered trainees)
VIEW AND BOOK ALL OUR EVENTS ONLINE

Event Online Services enables attendees to book single or multiple events quickly and efficiently, view full event listings, update personal details and make secure payments.

Website  www.rcoa.ac.uk/events
Twitter @RCoA_Events
Find us on Facebook

RCoA SUMMER SYMPOSIUM – BELFAST
Providing High Quality Anaesthetic Care in a Sustainable Healthcare System

13–14 JUNE 2017
The Waterfront Hall, Belfast | £395 (£295 for RCoA registered trainees)

TRADE EXHIBITIONS  SOCIAL EVENING  ABSTRACT COMPETITION  WORKSHOPS

For the 2017 RCoA Summer Symposium we have assembled a group of renowned national and international experts, who will present on a wide range of topics related to developing sustainable anaesthetic services which respond to the needs of the population, including the management of pain, patient safety, the perioperative pathways and ultimately patient outcomes.

The Symposium will also keep you up to date on the many recommendations stipulated as part of the sustainability and transformation plans in England and the Bengoa report on the transformation of healthcare in Northern Ireland.

Workshops
The following optional workshops are available to book at £25 per workshop and there will be 1 CPD credit awarded for each:
- Mentoring
- One lung anaesthesia
- Regional anaesthesia
- Surgical management of the failed airway.

Social Evening
Join us at the Arc Bar and restaurant on Tuesday, 13 June for a summer BBQ with drinks, waterfront views and entertainment. This informal event (included in the registration fee) will provide delegates with the opportunity to network and meet speakers in a social environment.

Abstract competition
Trainee anaesthetists are invited to submit an abstract on the topics of either Research or Audit for presentation at the Symposium (the submission deadline is midnight on Sunday, 2 April 2017). Cash prizes of up to £500 are available to the winners.

Book your place at:  www.rcoa.ac.uk/SummerSymposium

RCoA UPDATES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

17–18 MAY 2017
Glasgow Caledonian University | £355 (£270 for RCoA registered trainees)

This Scottish update meeting is a two-day event consisting of short, informative lectures with ample time for discussion. A wide range of topics will be covered by speakers, both local and from further afield, presenting up-to-date information, research and developments.

It is intended for doctors engaged in clinical anaesthesia, pain management and intensive care medicine, who would benefit from a refresher on the latest advances, controversies and challenges.

Knowledge gained will support your clinical practice and provide evidence that can be presented at appraisal and other annual reviews.

Book your place at: www.rcoa.ac.uk/events
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