A brief history of the future of training

Undergraduate teaching in anaesthesia, critical care, pain and perioperative medicine

Perioperative medicine: teaching on the world stage

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EVENTS CALENDAR

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NOVEMBER

Anaesthetists as Educators: Advanced Educational Supervision
13 November 2017
Park Inn by Radisson York City Centre
£220 (£165 for trainees)*

CPD Study Day
17 November 2017
Royal Hull Hotel
£200 (£150 for trainees)*

SALG Patient Safety Conference
22 November 2017
Manchester Conference Centre
£215

Leadership and Management: Working Well in Teams and Making an Impact
22 November 2017
£220 (£165 for trainees)*

Anaesthetists as Educators: ANTS (Anaesthetists’ Non-Technical Skills)
24 November 2017
RCoA, London
£220 (£165 for trainees)*

Joint RCoA/AAGBI Clinical Directors Meeting
28 November 2017
RCoA, London
By invitation only

December

Updates in Anaesthesia, Critical Care and Pain Management
11-13 December 2017
Royal Welsh College of Music and Drama, Cardiff
All days: £490 (£370 for trainees)*
One day: £295 (£180 for trainees)*

Trauma Care in Conflict: Civilian and Military Perspectives
Joint RCoA/Tri-Services Meeting
12 December 2017
RCoA, London
£200 (£150 for trainees)*

Joint RCoA/LSORA Regional Anaesthesia Workshop
13 December 2017
RCoA, London
£240 (£180 for trainees)*
Book both the workshop and symposium and save £100 (£70 for trainees)*

Joint RCoA/LSORA Regional Anaesthesia Symposium
14 December 2017
RCoA, London
£200 (£150 for trainees)*
Book both the workshop and symposium and save £100 (£70 for trainees)*

January

CPD Study Day: Evidence Base in Current Anaesthetic Practice
30 November 2017
RCoA, London
£200 (£150 for trainees)*

Primary FRCA Masterclass
9-12 January 2018
RCoA, London
All days: £305
One day: £80

Final FRCA Revision Course
15-19 January 2018
RCoA, London
All days: £395
One day: £95

February

CPD Study Day: Paediatric Anaesthesia
1 February 2018
RCoA, London
£200 (£150 for trainees)*

Anaesthetists as Educators: Teaching and Training in the Workplace
1-2 February 2018
RCoA, London
£425 (£320 for trainees)*

Joint RCoA/LSORA Regional Anaesthesia Workshop
13 December 2017
RCoA, London
£240 (£180 for trainees)*

Joint RCoA/LSORA Regional Anaesthesia Symposium
14 December 2017
RCoA, London
£200 (£150 for trainees)*
Book both the workshop and symposium and save £100 (£70 for trainees)*

March

CPD Study Day: Perioperative Medicine
28 February 2018
RCoA, London
£200 (£150 for trainees)*

Airway Workshop
7 February 2018
RCoA, London
£240 (£180 for trainees)*

Ultrasound Workshop
1 March 2018
RCoA, London
£240 (£180 for trainees)*

Introduction to Leadership and Management: The Essentials
7-8 March 2018
Novotel Hotel, Sheffield
£395 (£300 for trainees)*

April

CPD Study Day: Managing Mass Casualties
18 April 2018
RCoA, London
£200 (£150 for trainees)*

Airway Workshop
18 April 2018
RCoA, London
£240 (£180 for trainees)*

Quality Improvement and Patient Safety: Improvement Science
21 March 2018
RCoA, London
£150 (£115 for trainees)*

May

Joint RCoA & AAGBI event
22 March 2018
AAGBI, London
Please see the AAGBI website for booking and fee information:
www.aagbi.org/education/event/3428

June

ANAESTHESIA 2018
International Meeting of the Royal College of Anaesthetists
22–23 May 2018
British Museum, London

*Delegates must be RCoA registered trainees to be eligible for the trainee rate.
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An emerging opportunity for anaesthetists?

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From the editor

Professor Monty Mythen

Welcome to the November Bulletin.

While reviewing the contents of this issue, it was clear to see the impressive scope of work being undertaken by teams across the College in support of its membership. But importantly, it was heartening to see fellows and members giving of their time to become intricately involved in this work in order to drive forward the activities of their College for the benefit of their specialty and their anaesthetic colleagues.

Far from the traditional corporate notion of ‘it’s August – things slow down in August...’, the College and its membership have been incredibly busy over the summer months working together to address important topics.

This issue proves just that from:

- College Council Trainee member Dr J-P Lomas’ up-coming report into trainee morale and wellbeing
- development of an undergraduate educational framework for anaesthesia and perioperative, pain and intensive care medicine
- creation of a new membership category for medical students and foundation doctors
- initiating a review of the CCT curriculum and its alignment to new GMC Standards and;
- work to develop the new e-portfolio system under the College’s Technology Strategy Programme.

This edition of the Bulletin serves up just a flavour of how the College continues to work hand-in-hand with its membership to improve working conditions and education opportunities for anaesthetists across the United Kingdom.

This issue’s guest editorial from Dr Abigail Whiteman and Dr Phil Sherrard from University College London Hospitals is a must-read. Here, the College’s involvement in the development and funding of a Massive Open Online Course (MOOC) in perioperative medicine demonstrates how popular this form of education is. The Perioperative Medicine in Action MOOC benefitted from the collaboration of over 50 perioperative medicine experts from more than 50 institutions to attract over 4,000 registered learners from across the globe. This is a huge success for the College and our work to spread the teachings of perioperative medicine. Congratulations to Abigail, Phil and the College’s Research team who worked hard to make this the success it was.

Also featured is the third annual patient report by the National Emergency Laparotomy Audit (NELA) team. This is another example of how hospital staff and clinicians from 187 hospitals across England and Wales worked with the College to submit and analyse data on almost 25,000 emergency laparotomy patients. This huge and crucially-important piece of work is brought into context by Donna Armitage-Taylor – an emergency laparotomy patient who recounts her experience of being treated by multidisciplinary teams during her procedure. Donna (quite rightly) praises the work of the NELA team in the collection of data in order to drive up the standards of patient care.

There’s so much more in this issue but, I’ll take this opportunity to encourage fellows and anaesthetists in training to vote in the Council elections (see page 67). Lastly, but certainly not least, do book your place for the College’s new flagship event in May 2018 – Anaesthesia 2018 (see page 68). There are still early bird rates available, so please book your place to take advantage of this.
A BRIEF HISTORY OF THE FUTURE OF TRAINING

Dr. Liam Brennan, President

The President’s View

As I write this article, the unpredictable UK summer bows out for the greater unpredictability of autumn. When you read this, the branches outside are likely bare, but for now the leaves are still turning from greens to copper. This time of year has often been a metaphor through which one reflects on the theme of the future. Normally, this would offer the ideal backdrop to this month’s piece on the future of training. However, a very different development acts as a starting point for this month’s article...

In September, a very public debate between Emeritus Lucasian Professor of Mathematics, Stephen Hawking and the Secretary of State for Health, The Rt Hon Jeremy Hunt, played out in the national media.

While this article is not the place to go into great detail about my take on this, I was nevertheless drawn to Professor Hawking for inspiration for this month’s article, as I can think of few more qualified to provide inspiration on the topic of the ‘future’, than the author of *A Brief History of Time*.

Before discussing the future of anaesthetic training, I wanted to share a positive assessment of the present – or the very recent past to be entirely correct.

The RCoA College Tutors meeting in June this year was evidence for this positive outlook, as over 300 College Tutors, Regional Advisers Anaesthesia (RAAs), Heads of Schools (HoS), and Training Programme Directors (TPDs) came together for the benefit and development of the future of our specialty. From the talks I heard and the conversations I had in Belfast, it was clear that the future of training in our specialty looks bright, in the hands of highly motivated and skilled clinical trainers offering professionalism, empathy and an uncommon sense of pride in developing the anaesthetists of tomorrow.

But the other ingredient required are motivated and properly supported anaesthetists in training – and the RCoA morale and welfare survey provides a snapshot of the pressures the entire health and social care system is under, for which trainees have been a lightning rod.

As the future of the specialty, anaesthetists in training continue to be one of the most valued cohorts in our profession. However, the morale and welfare survey painted a stark picture of trainees feeling undervalued and overwhelmed while working tirelessly to meet the demands of specialty training and the expectations of patient care.

Over the past 12 months I have been spending time across the whole of the UK, speaking directly to trainees via a series of Listening Events. These events have allowed myself, the Council and our senior management team to gain a deeper understanding of the pressures faced by today’s...
trainees. A full report of trainee morale and wellbeing, incorporating the results of the survey, insight from the Learning Events, and other data such as the joint RCoA-AAGBI survey on the impact of fatigue, will be published before the end of the year. The report, led by College Council Trainee member Dr J-P Lomas, will include a number of recommendations for national policymakers and hospitals to help ensure that our trainees are adequately valued and supported to gain maximum benefit from their training in anaesthesia and to develop into tomorrow’s healthcare leaders.

It is important to note that the results from the trainee survey are not unique to anaesthetists in training, but the issues highlighted are just as applicable to consultants and SAS doctors alike. Many of the recommendations in the report will point to changes which can make a positive impact for all grades in our specialty.

From undergraduate to postgraduate

While we continue to support doctors in specialty training, our first five-year strategy started to move forward the College’s ambition to also support students taking their first steps into a career in medicine. To begin this process, we have reached out to engage with anaesthesia leads within medical schools across the UK, to explore how exposure to anaesthesia, pain medicine, and intensive care medicine, which will be published before the end of 2017. We have an ambition to develop our links with medical schools which provide the groundwork for how medical students and foundation doctors make important choices about their careers.

The launch of the undergraduate framework will be coupled with the announcement of a new College membership category for medical students and foundation doctors who are looking to develop their professional identity as they begin to navigate their future career path.

In the area of postgraduate training we have established a number of College working groups to initiate a review of the CCT curriculum and its alignment to the new GMC Standards: Excellence by Design. Standards for postgraduate curriculum (http://bit.ly/2wl13CJ). The new standards require all future curricula to be outcomes based – rather than competency based – in order to improve flexibility and transferability of skills, maximise professional judgements (which then inform formative assessments) and also reduce the administrative burden for trainees and trainers alike.

All curricula will be expected to comply with the Excellence by Design standards by 2019, and we will be using our previous work on the Devlin Review, the Shape of Training Review and guidance from the Academy of Medical Royal Colleges, as the basis of our work.

Continuing Professional Development (CPD)

But of course, learning doesn’t finish with the completion of formal training. We all have a duty to regularly refresh our knowledge and skills and keep up to date with new developments in our specialty, CPD outside of formal undergraduate or postgraduate training is an integral part of good medical practice, ensuring non-training grades continue to develop alongside the latest standards, technology and medical innovation.

Since the turn of the 2017, the College has been making a significant investment in its events programme, with new staff and a new strategy. Our next set-piece Anaesthesia 2018 event (www.rcoa.ac.uk/anaesthesia) will be taking place next May at the British Museum in London. It will bring together national and international experts to present the latest advances in anaesthesia, perioperative medicine, critical care and pain medicine.

As part of our 25th anniversary programme, our series of ARIEs talks (www.rcoa.ac.uk/arielibrary) has taken us from battlefields in Afghanistan to the top of Mount Everest and even beyond earth’s orbit, to anaesthesia in space. There are a number of ways in which the College is showcasing the wealth of expertise held by our 22,000 fellows and members, to offer new perspectives from across (and beyond) the globe, and share new ideas which can translate to improved delivery of day-to-day services for our patients.

Next steps

The RCoA’s five-year strategic plan initiated a process of modernisation for the College, and upgrading our training and educational resources is a vital part of this work.

As part of an ambitious technology programme the new trainee e-portfolio is currently in a prototype stage and we are actively consulting with College Tutors, TPDs, HoS, RAsA and trainees on developing the system’s functionality. There have been consultations on how the Annual Review of Competence Progression (ARCP) process should work, including multisource feedback, sign-off processes and plans for ‘go-live’, and we will be keeping the training community and trainees regularly informed of progress in this area.

The Secretary of State for Health, The Rt Hon Jeremy Hunt MP, has made a commitment to expand medical school places in England by 1500 from September 2018. However, the increased cohort of medical students will not graduate until 2023 and would not be anticipated to complete specialist training in anaesthesia until 2032. At current rates of demand-growth we anticipate that every hospital will be short of between 10 and 20 consultants by 2033. I am continuing to raise these issues concerning the anaesthetic workforce at the highest levels, including government ministers, the UK’s chief medical officers and senior figures within the NHS.

Conclusion

It would be understandable to read the results of welfare and morale surveys, about the ongoingissant with pay restraints and inadequate investment, and the projections of workforce shortages and think the autummal storm clouds are here to stay.

But I continue to believe that we have proven ourselves to be an adaptable and resilient specialty. The College is playing an increasingly effective role in supporting anaesthetists of all grades and engaging medical students in advance of specialty training. Green shoots of new initiatives, technology and outreach programmes are all reasons to be encouraged that, after the many depressing issues highlighted are just as applicable to consultants and SAS doctors alike. Many of the recommendations in the report will point to changes which can make a positive impact for all grades in our specialty.

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News in brief

News and information from around the College

**RCoA 3D virtual exam tours**

A new 3D virtual tour of the Royal College of Anaesthetists' building is live and available to view online. The latest in our series of interactive resources for examination candidates, the 3D tours provide a virtual version of Churchill House in Holborn, which our members can experience via their computer, mobile device or virtual reality headset.

For many fellows and members, their first experience of visiting their College building is to attend examinations. Through this new resource, members can familiarise themselves with the building and better prepare for upcoming exams.

One of the 3D models shows the Primary FRCA OSCE Examination floor. Within this model, virtual labels detail interesting aspects of the exam environment. There are also other videos demonstrating examples of different exam scenarios. The intention is to replicate the exam environment as accurately as possible, so candidates visiting their College know what to expect and are provided the best opportunity to demonstrate their abilities in the exam.

Another model shows the College building from the lower ground floor to the second floor. This is not only useful for exam candidates, but also for people visiting the building for meetings or thinking about holding their own event here. Links to each 3D tour and a short ‘how to’ video are available here: [http://bit.ly/primaryRCAnosources](http://bit.ly/primaryRCAnosources).


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**Trainer Award**

Dr Claire Sheppey has been posthumously awarded an RCoA 25th Anniversary Trainer Award, which recognises the excellent contribution she made to the delivery of anaesthetic training.

Dr Sheppey was a consultant paediatric anaesthetist at the Royal London Hospital where she is fondly remembered as a highly skilled clinician and an inspirational and dedicated teacher and trainer. Members of Claire’s family, her colleagues and RCoA staff recently gathered at the College for the presentation of the award.

**Member journals: a new publishing partnership**

With effect from 1 January 2018, publication of the College’s two academic journals and the membership magazine Bulletin will move from Oxford University Press to Elsevier. Fellows, members and non-member subscribers will continue to benefit from their printed copies as well as online access to the British Journal of Anaesthesia and BJA Education.

The RCoA 2016 membership survey showed that 91% of fellows and members read BJA Education, 90% read the BJA and 84% read the Bulletin. Eighty-six percent of survey respondents rated the College’s publications as ‘very good’.

Alice Dartnell, Head of Membership Engagement said: ‘This is high praise indeed from our fellows and members and it is for this reason that we are so committed to continue providing publications which are relevant, timely and professional. With the BJA’s impact factor having recently increased for the fourth consecutive year to 6.238, the BJA is now the number one ranking journal in the field of anaesthesia. The College is working hard with Elsevier to ensure a smooth and seamless handover.’

More information about the transition, including details of online access from January, will be provided via the President’s eNewsletter ([www.rcoa.ac.uk/presidents-news-archive](http://www.rcoa.ac.uk/presidents-news-archive)).

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**BJA**

British Journal of Anaesthesia

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**ANAESTHESIA 2018**

International Meeting of the Royal College of Anaesthetists

22–23 May 2018

British Museum, London

As part of the College’s emerging education strategy, and after listening to input from our fellows and members, the College looks forward to hosting in May, our first annual two-day international conference: Anaesthesia 2018.

Taking place on 22 and 23 May 2018 at the British Museum in London, Anaesthesia 2018 will replace the College’s annual Anniversary Meeting and Summer Symposium, and is set to be a must-attend event for anaesthetists.

To celebrate the launch of this new event, we introduced an early bird rate, meaning the first 50 delegates to register received a discount of 15%. We were pleased to see how popular this was and hope to roll out similar offers at other events to make them more accessible, in addition to our existing discounts for RCoA registered trainees and senior fellows.

Russell Ampofo, Director of Education, Training and Examinations said: ‘We’re committed to delivering a relevant education programme founded on feedback from our fellows and members and it’s exciting to see this being put into practice with Anaesthesia 2018. With delegates already registered from as far afield as Malaysia and Australia, and internationally renowned speakers on the programme, I’m looking forward to two days of learning, engaging conversation and debate – I hope to see you there.’

For further details and to book your place at Anaesthesia 2018, visit:

[www.rcoa.ac.uk/anaesthesia](http://www.rcoa.ac.uk/anaesthesia)
The College is pleased to report that the National Emergency Laparotomy Audit (NELA) has been recommissioned for a further three years, from December 2017 to November 2020. NELA is a national improvement initiative led by the Royal College of Anaesthetists and designed to improve patient outcomes following emergency bowel surgery. The audit is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit Programme. Since NELA’s establishment in 2014, more than 80,000 patient records have been collected from all hospitals across England and Wales which perform this type of surgery.

Huge credit for the success of NELA must go to all the hard-working colleagues at local level who tirelessly collect and input their hospital-specific data. It would not be possible for the audit to achieve its objectives without your engagement and support – thank you.

Dr Liam Brennan, President of the RCoA said: ‘NELA is an excellent example of where working closely with our surgical colleagues and HQIP is resulting in real clinical improvements in hospitals. We are pleased to be continuing our work with HQIP to improve care and help save hundreds of lives every year.’

Professor Sir Bruce Keogh, National Medical Director at NHS England, described NELA as a template for how quality improvement led by hospital doctors can deliver improved patient outcomes within the NHS.

NELA’s Third Patient Report was published in October 2017, reporting on the care received by close to 25,000 emergency laparotomy patients between December 2015 and November 2016. You can read Dr Sarah Hare and Dr Dave Murray’s article about this third report on page 32.

Visit www.nela.org.uk and follow @NELA_news for more information.

**Medical students and foundation year doctors**

The College is pleased to announce the launch of a new membership service for medical students and foundation year doctors. The new membership service also supports the Undergraduate Curriculum, launched in November.

The new membership service offers support for those interested in learning more about anaesthesia as a specialty. As part of the membership benefits offering, students and foundation year doctors will receive:

- access to information and materials on how to embark on a career in anaesthesia
- discounted access to RCoA events
- access to RCoA webcasts
- access to a dedicated area on the RCoA website
- information about the training programme and tips for success
- an electronic version of the Bulletin.

For more information, please visit the College website: www.rcoa.ac.uk or contact your membership team on membership@rcoa.ac.uk or 020 7092 1700.

Thanks to Dr Jonathan Sadler, RCoA Education Fellow 2016/2017, the Medical School Anaesthesia Societies, and Dr Clare Van Hamel, Head of Foundation School at Severn Deanery for their involvement and support of the membership category launch.

**SafeguardingPlus**

**New information for anaesthetists**

The College has launched SafeguardingPlus – a new resource of peer-reviewed information to provide advice for anaesthetists on how to identify, manage and prevent harm in patients and improve understanding of consent and ethical issues.

Protecting adult and child patients from harm and abuse is the responsibility of practitioners from all medical specialties, and anaesthetists play a particularly critical role in safeguarding due to their work across the perioperative pathway.

The SafeguardingPlus web pages (www.rcoa.ac.uk/safeguardingplus) have been developed as a reliable and quick reference guide that will prove valuable in patient care as well as for personal and departmental CPD.

We hope the new web pages will help support anaesthetists to deal with a safeguarding concern, or a consent or ethical issue in the perioperative setting, whether it relates to a child, young person or an adult, wherever they work in the UK. The web pages contain key references, bespoke resources and materials and also provide links to shorter pieces on specific topic areas, including confidentiality, duty of candour, restraint, and DNACPR, with signposting to well-developed and up-to-date guidance.

We would like to thank the many fellows, members and colleagues in other specialties who drafted, edited and peer reviewed this new content.

**SAFE ANAESTHESIA LIAISON GROUP**

**Patient Safety Conference 2017**

The Safe Anaesthesia Liaison Group’s (SALG) 2017 Patient Safety Conference is now just a matter of weeks away. A partnership between the College, Association of Anaesthetists of Great Britain and Ireland (AAGBI) and NHS Improvement, SALG aims to highlight potential or existing patient safety issues to those practicing anaesthesia.

The Patient Safety Conference will take place on 22 November 2017 in Manchester.

In addition to presentations from the presidents of the RCoA and AAGBI, the meeting will consist of lectures and discussion for doctors with a particular interest in improving patient safety within clinical anaesthesia, pain management and intensive care medicine. Keith Corradi, Chief Investigator of the Healthcare Safety Investigation Branch, will deliver the keynote presentation.

The conference will provide the opportunity for delegates to share ideas with colleagues. Trainees will have the opportunity to participate in a competition including both oral presentations and a poster exhibition.

For more information please visit www.rcoa.ac.uk/PSC2017 and be sure to book your place early. If you have any questions please contact SALG@rcoa.ac.uk.
Guest Editorial

Perioperative medicine: teaching on the world stage

Dr Phil Sherrard, Education Fellow, University College London Hospitals

Dr Abigail Whiteman, Consultant in Anaesthesia, University College London Hospitals

Dr David Walker, Consultant in Anaesthesia and Intensive Care, University College London Hospitals

Adoption of the principles underpinning perioperative medicine is now accepted as an important priority to improve surgical patient outcomes. Delivery of high-quality patient care by a multidisciplinary team is one of the main concepts behind perioperative medicine. However, this integrated approach will not succeed unless it is adopted, not only by anaesthetists, but also by the entire healthcare team. The key to ensuring adoption and sustainability of any institutional change is education.

As a new and developing specialty, any institutional change is education. As their name suggests, they are online courses that are free to access with a limitless number of participants. Our proposal was for a course entitled Perioperative Medicine in Action. As is typical for a MOOC, it would be four weeks long with three hours of learning per week. The course would be aimed at all interested healthcare personnel, both medical and allied health professionals, to introduce the key concepts behind perioperative medicine.

After securing funding, we set about designing our course and curriculum, the overall process of which took around three months to complete. Curriculum construction was assisted by the use of a UCL workshop, which mapped educational steps to learning activities. These activities included written articles, summary articles of key documents, group discussion steps, video content and also exercises encouraging learners to undertake their own research to complete learning aims.

Each week was designed to tell a narrative story to engage the learner with every educational point centred back to a patient’s story. The course content is summarised below.

- **Week 1**: The need for perioperative medicine.
- **Week 2**: Risk assessment and shared decision-making.
- **Week 3**: Protocols in surgical care.
- **Week 4**: Perioperative care for the elderly surgical patient.

The building of the course took another three months to complete. Curriculum design and writing were mainly suited to learners who want to make a significant commitment to specialising in the field, as future perioperative medicine leaders. We believe that to really deliver the ideals of perioperative medicine, education must occur throughout all grades and amongst all healthcare professionals working with surgical patients.

In 2016, the Centre for Anaesthesia and Perioperative Medicine at UCL secured funding to develop a Massive Open Online Course (MOOC) to be delivered on the commercial platform FutureLearn. MOOCs were originally launched in 2008 and have since become a credible and valuable educational resource in online education. As their name suggests, they are online courses that are free to access with a limitless number of participants. Although this is recognised as an extremely good completion rate of under 10%, a drop off appears dramatic, for a MOOC this is recognised as an extremely good retention rate, where there is an average completion rate of under 10%.

The course was launched for its first run on 3 July 2017. A total of 4,020 learners registered interest. Figure 3 demonstrates the international reach of the course with enrolments from across the globe even in countries as far away as Rwanda, Angola, Colombia and Nepal. Over 3,000 learners went on to participate in the course, 32% completed more than half the course and a quarter completed all the educational material. Although this drop off appears dramatic, for a MOOC this is recognised as an extremely good retention rate, where there is an average completion rate of under 10%.

The course underwent an extensive quality-assurance assessment by teams from UCL, the RCoA and FutureLearn. We are very grateful to the RCoA Perioperative Medicine Leadership Group for their support and advice, which were pivotal in making this project a success.

Figure 1

Perioperative medicine as a concept

In the previous step you discussed what a perioperative pathway might look like. Over the next few steps we will explore the Royal College of Anaesthetists’ vision of high quality perioperative care and hear about a successful example of a perioperative care pathway from York Teaching Hospital.
The most exciting part of running the course was witnessing the interaction between all the learners. Every step offered the opportunity to enter into discussion with other learners. There were over 5,500 comments posted over the whole course. All members of the multidisciplinary team felt empowered to contribute to these discussions, sharing ideas and learning from each other. Controversial ideas, including who should lead the perioperative team, the role of GPs and how we can afford perioperative medicine, were heatedly debated.

The overall process from conception to launch of the MOOC has taken just over a year. It has involved a team of over 70 professionals and has all-consumed the team of two writing this article! As the field of perioperative medicine develops, we will continue to update and improve the course, hopefully including many more examples of excellent perioperative practice from around the world.

We would like to invite you and all members of your multidisciplinary team to join us on the second run of the course in November 2017 – to find out more, see: 

www.futurelearn.com/courses/perioperative-medicine

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References

Figure 2 Week 2 – risk assessment and shared decision-making

Figure 3 Demonstrates the international reach of the course with enrolments from across the globe

Shared decision-making in action

Dr Mike Swart runs a high risk pre-assessment clinic in Torbay. In the above video you can watch an example from the clinic about an elderly patient, Ralph, trying to make a decision about operative versus non-operative management for an abdominal aortic aneurysm.

Figure 3

Anaesthesia Clinical Services Accreditation (ACSA)

Taking forward the work of the Clinical Service Accreditation Alliance (CSAA)

Dr Roland Valori, Clinical Lead for Accreditation, Healthcare Quality Improvement Partnership (HQIP)

The CSAA was created in 2013 following an agreement for a core group of professional bodies to develop an overarching strategy for clinical service accreditation. Our purpose was to harmonise processes, provide guidance and ultimately alleviate the burden of inspection on staff.

The work of the alliance concluded in November 2016 with the publication of a suite of resources to support professional bodies working to create a professionally led and patient-centred clinical accreditation scheme. These are now available to download from the HQIP website www.hqip.org.uk.

Now called Clinical Service Accreditation (CSA), I am pleased to report that the work of the alliance continues to advance, in part, to test the resources developed in practice. This will be hosted by HQIP and supported by a sponsor group† comprising six professional bodies that were members of the original CSAA. As a group, we are collaborating to sustain and develop the long-term aims of the CSAA. We were delighted to welcome the RCoA to the group’s membership in late 2016.

So, what does the future hold for the CSA? Over the next 12 months our work will take the form of four key strands:

- maintaining and updating the outputs of the six original work streams
- piloting our resources by aiming to work with and support two clinical services interested in developing an accreditation scheme. In particular, developing practical resources to underpin the guidance ‘Developing accreditation schemes for clinical services’
- creating an in-house accreditation consultancy faculty to support clinicians
- collaborating with key partners including:
  - The Care Quality Commission (CQC) – to develop an understanding of how accreditation can support the new CQC inspection methods.

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*Allied Health Care Professionals (until July 2016), Allied Health Professions Federation, Healthcare Quality Improvement Partnership, Royal College of Nursing, Royal College of Physicians, Royal College of Surgeons of England, Royal Pharmaceutical Society.

If you are interested in finding out more, please visit:

www.hqip.org.uk/national-programmes/accreditation-of-clinical-services/

or subscribe to the CSA e-Bulletin by emailing accreditation@hqip.org.uk

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or subscribe to the CSA e-Bulletin by emailing accreditation@hqip.org.uk
The scheme has changed considerably since the early days. But what hasn’t changed is that it remains a supportive, friendly peer-review and quality-improvement process. Having been involved with ACSA since the pilot in 2012 and recently undergone an ACSA review in my department, I am able to share my experience of the process from both sides.

So, what have I learnt during my many visits as a reviewer and more recently having hosted a review team in my department?

It’s important to ensure buy-in from the whole department

Don’t just rely on a few enthusiastic colleagues to do all the work. Ensure that progress is discussed at departmental meetings.

Don’t underestimate the amount of work required, even if you think you are compliant with the majority, if not all, of the standards. Invariably, there will be policies that will need to be written entirely from scratch, some that are past their review date requiring modification, some standards that need evidencing by recent audits – and the list goes on. You will need the ‘many hands’ of your colleagues to ‘make light work’ of what is required. Even after poring over the standards and the evidence gathered for months, be prepared for the ACSA team to unearth a blindingly obvious non-compliance, as happened to me, much to my discomfiture. It did provide some amusement though to the ACSA Review Team.

College guides are an invaluable resource

Don’t hesitate to contact them for advice, or if you think you might struggle to comply with a particular standard. They will be able to point you in the right direction.

The ACSA team are friendly and supportive

If you’re ‘lucky’ enough to be the ACSA lead, you cannot escape the feeling of stress during the final days leading up to the visit and the actual visit itself. I can, however, guarantee that you will be surprised by the friendly approach and the supportive ethos underlying the whole process.

Have a Plan B

It will help stress levels to always have a Plan B or even a Plan C. Be prepared for your car to have a punctured tyre on the morning of the first day of the visit (no, this didn’t happen to me) or for the hospital IT system to go down just as you are about to start your presentation for the review team (this one almost did). ‘Enjoy’ all these mishaps, for they will make interesting anecdotes for you to reminisce about in the future.

Remember why the process is important

Most importantly, whilst doing all of the above, don’t lose sight of what ACSA is actually about. It is not a snapshot pass or fail, but a supportive process of continuous quality improvement in service delivery for your patients. It is not just about ensuring that all your policies are in place but, quite rightly, ensuring that those policies are actually translated into improved and safer patient care.

There might be some hesitation in putting up your department for voluntary scrutiny by an external team, but it will bring benefits. Undertaking this process will unify the department with a shared goal of improving patient care and safety. The sense of pride and achievement from ACSA accreditation is definitely worthwhile. To top it all, you will have a RCoA plaque to show off to your trainees, potential recruits and your surgeons.

References


Anaesthesia Clinical Services Accreditation (ACSA)

**MY ACSA EXPERIENCE**

**Dr Sandeep Lakhani,**
Clinical Director of Anaesthesia and Intensive Care,
The Walton Centre NHS Foundation Trust

Hopefully, you will have heard of ACSA by now. ACSA, the RCoA’s anaesthetic accreditation scheme, was officially launched in 2013 but had been in the making since 2011. It is heartening to note that despite ACSA being a completely voluntary scheme, there are currently 16 accredited departments and a further 93 engaged in working toward accreditation.
Early prognostication in patients with devastating brain injury can be very difficult; occasionally patients may make a good recovery despite very poor early prognostic signs.

In view of a reported variation between ICUs regarding admission practice for patients following perceived devastating brain injury, the FICM/Intensive Care Society Joint Standards Committee established a working party. This group has now produced a consensus statement with partner organisations on the management of patients with perceived devastating brain injury after hospital admission, which is due to be published in the BJAn and will be available on the FICM website. They highlight that a period of observation following physiological stabilisation is recommended in order to improve the quality of decision-making. Patients who are intubated will require admission to critical care for this period of observation, unless the extent of co-morbidity makes continued organ support of no overall benefit regardless of the extent of potential neurological recovery.

Building on the experience of the WHO surgical safety checklist and to support the development of local safety standards for invasive procedures performed outside the operating theatre environment, the JSC has developed examples of safety checklists for common invasive procedures undertaken in ICU including intubation, central venous cannulation, tracheostomy and bronchoscopy. These are available to download from the FICM website.

The planning towards producing GPICS (Guidelines for the Provision of Intensive Care Services) Version 2 is well underway with an expected publication date in Autumn 2018. A consultation process has been completed by way of a survey sent to all FICM (and ICS) members and endorsing organisations. One clear message that emerged concerns the challenges faced by small and specialist units in achieving all the standards of GPICS whilst they are still able to deliver good outcomes. The FICM Small and Specialist Unit Advisory Group will be both contributing to a new section on remote and rural units as well as acting as a key consultation resource for wider issues impacting smaller urban and specialist units.

The new membership working party

Dr Peter Macnaughton,
FICM Co-Chair, Joint Standards Committee (JSC)

Non-anaesthetic fellowship
There is an opportunity to improve our liaison with colleagues working in the field of pain medicine that currently have no direct connection to the FPM (other than the few who have achieved a form of honorary fellowship). Several hospital consultant groups may be interested. This will be a complex change to the regulations for fellowship and so we intend to map out the work initially for one specialty group. We are currently taking forward preliminary discussions with their respective training committees and will expand to other specialties in time.

The current curriculum, training programme, exam and managerial structure are considered appropriate for all specialists, regardless of specialty background, and can absorb further advanced pain trainees. Time-limited ‘grandfathering’ arrangements are being considered for non-anaesthetist pain medicine specialists who are already consultants.

Acute/inpatient affiliate membership
Following discussion with current acute pain consultants led by Dr Mark Rockett, the Board’s acute pain representative, there is a clear desire from this group to have a closer association with the FPM. However, since the end of the Foundation Fellowship, all routes of membership have required sessions in chronic pain.

There are two strands to this: Firstly, attracting current consultants who have acute pain sessions and commitment, and secondly, trainees developing an interest in the area. A route of affiliate fellowship is being investigated currently. There may be an opportunity to access a path to full fellowship but this has implications on entry rules to the examination and so is under consideration. We will communicate further developments as the working party continues to take this work forward.

Faculty of Pain Medicine (FPM)

Dr John Hughes,
Vice Dean, Faculty of Pain Medicine

Following external interest and the Board’s desire to broaden its support to consultants working in or associated with pain management, the FPM with agreement from RCoA Council is investigating two new routes of entry.

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We will communicate further developments as the working party continues to take this work forward.
‘And finally, what are the three pieces of music your mum would have liked at her funeral?’

I said I had no idea but that I would get back to the funeral director.

‘That’s all right but don’t leave it too long – we need to print the service details soon.’

My mother had died peacefully and we wanted everything to go smoothly – including her favourite pieces of music.

I thought long and hard but this would be my selection, not hers. If only we had talked about it. I was floundering and, with no more ideas, I phoned one of Mum’s closest friends and, suddenly, all was settled.

‘Oh yes – I know exactly. You know your mum and I talked about the services we would want and the music and poems we would like. Have you got a pen to write them down?’

What a relief! The service went well and afterwards I thanked my mum’s friend again, and asked if she had told her nearest and dearest about her choices of music.

‘Not yet – but I think I ought to. And it’s not just the music and poems! But I don’t want to upset anybody else talking about these things.’

This small incident seems to underline much broader and deeper issues that we all face. An ICM survey in 2006† found that only one-third of people had spoken about their end of life wishes, despite 80% thinking that it was important to do so. A similar British Social Attitudes survey in 2013‡ regarding feelings about death and planning for end of life found that 70% of participants would feel comfortable discussing death and only 13% were uncomfortable. The large majority of people can be broadly split into categories – younger people who regard death as a long way off and an older group who are concerned such discussions will upset other people.

At the same time, the so-called medicalisation of dying has caused increasing concern. Most people are unlikely to die in their preferred place of death, with the majority dying in hospital. Yet health and social care professionals report that they do not have sufficient training to meet the demands of end of life care – of the patient, or their families.

So, there seems to be a need and an acceptance of such discussions amongst a large proportion of the public. Recent books such as Being Mortal by Atul Gawande and documentaries like A Time to Live on the BBC may spur it on.

Of course, conversations about end of life wishes are not limited to doctors and patients. They also happen – or don’t happen but should – amongst families and carers. However, there are all the uncertainties, a welter of medical technicalities and even an acceptance of mortality to be faced in these conversations. Add in all the swirling emotions and complexities of relationships with family and loved ones and it is little wonder that we struggle to have them.

We have discussed this at the Lay Committee but found it very difficult to make any progress. So, I welcome the work at University College Hospital on the Big Conversation, which aims to encourage this sort of conversation between doctors, patients and loved ones by providing a framework of important questions to help get the discussion going. I hope that we will be able to work with the team to make some tangible progress.
Dyslexia is considered a disability under the Equality Act 20101 and as such ‘reasonable adjustments’ may be required of the RCoA, schools of anaesthesia and employers to avoid discrimination. The very nature of anaesthetic training – with frequent moves between hospitals and variable understanding amongst trainers of the challenges faced by trainees with dyslexia – may reduce the opportunity for reasonable adjustments to be put in place.

For trainees, coping strategies that have worked while at university may not be available in clinical settings. The use of a clipboard or carrying a notepad can appear unconventional and may require support from trainers. Bad experiences in the past may lead to a lack of confidence and a feeling of isolation. Trainees may choose to conceal their difficulties rather than risk direct discrimination. Inevitably, in so doing there is an increased risk of indirect discrimination and those with responsibility to provide ‘reasonable adjustments’ will not have the opportunity to do so.

Disability is well recognised in the exam regulations of the FRCA in Appendix 3.2 The RCoA provides suitable adjustments when it is made aware of requirements in advance. Schools and employers also have a responsibility to develop a workforce that recognises dyslexia and can offer appropriate support. Mandatory training is a particularly blunt tool – educational supervisor training is important and schools may be able to get individual support from university-affiliated learning support teams.

The educational supervisor is key to helping a trainee with dyslexia to quickly thrive in a new environment. However, the trainee has to be confident that the response to their disclosure of dyslexia will be a positive one. This can be facilitated by appropriate information at induction, a departmental culture of inclusion, and educational supervisors that proactively seek every trainee’s preferred learning style and offer support. It is particularly important to agree clear, measurable learning objectives and establish early what reasonable adjustments are needed.

General principles

- Trainees may struggle with both immediate and long-term recall of numbers, times and names. Without reasonable adjustments, supervisors may perceive these as poor organisational skills. Some trainees with dyslexia might also struggle to understand exactly what is expected of them in a busy environment. Clear oral instructions are needed, while the ‘hint and hope’ of the days before human factors training can be particularly unhelpful.
- ‘Photographs of work colleagues with names and roles displayed in a prominent place alongside a hospital map’ may be helpful as there can be difficulty in remembering roles and responsibilities.
- Trainees with dyslexia may take longer to learn to follow a sequence, such as that required in central line insertion. The established ways of teaching a new technique by repeated demonstration are important, but also the less conventional use of spider diagrams and mind maps may help as part of preparation. Written information may be helpful.
- The trainee may have developed their own approach to tasks, such as performing procedures in a certain order, or adapting techniques in unconventional ways. Clinical educators may disable their trainees if they do not recognise these compensatory techniques.
- Keep in mind ‘is this trainee competent to do the task?’ instead of ‘can this trainee do it like me?’
- A trainee with dyslexia may appear unconventional and may require ‘reasonable adjustments’ will not have the opportunity to do so.

- Multisource feedback or other assessments should be viewed in the context of dyslexia. This may be regarded as a reasonable adjustment.
- Trainees with dyslexia have varying patterns of strengths in important skill areas including creativity, lateral thinking, problem solving and visual thinking. Departments and trainers should recognise and encourage these strengths.
- The development of secure online discussion forums for trainees with dyslexia by both schools and the RCoA would allow mutual support. The best advice may well come from people who have faced and overcome similar problems before.

Further information

British Dyslexia Association
www.bdadyslexia.org.uk

References

Feedbac from the latest ‘New to the NHS Day’
This year we had an excellent turnout of 21 SAS doctors. We ran a joint programme in the morning with the focus on the General Medical Council (GMC) and educational opportunities.
In the afternoon, there were separate streams and SAS doctors focused on revalidation and Certificate of Eligibility for Specialist Registration (CESR). One of my own colleagues, Dr Zdenek Bares, gave a very honest account of his experience having come to the UK last year. Fortunately, most of it was positive.

He is in the hospital for less time than in his home country since the European Working Time Directive is actually applied here. He feels the pay is fair. There is study leave and funding for CPD as well as generous annual leave. Consultant support is good with a flat hierarchy. He also notes that all hospital specialties are considered equal in status which is not the universal experience of anaesthetists working in other countries.

Downsides included the bureaucracy and expense of the GMC. Shorter hours for doctors can mean less continuity of care and less experienced surgical trainees. He has also had to adjust to new anaesthetic drugs and the absence of some with which he is very familiar. Also, he was not used to working with Operating Department Practitioners (ODP) and finds they can vary a lot in their extended skills.

The feedback from ‘New to the NHS’ was excellent. Those who attended would definitely recommend it. If you have new colleagues from abroad, look out for the meeting next summer.

SAS survey findings and Listening Events
The SAS survey findings were released at the Summer Symposium in June. Since then, they have been shared widely with other colleges through the Academy of Medical Royal Colleges and the British Medical Association (BMA). Work goes on jointly with the BMA and AAGBI to produce an action plan for all three organisations to take forward from early next year.

The College has also run successful Listening Events for trainees and we are proposing to do this for SAS doctors this month in Newcastle. The College will be holding workforce meetings in regions with recognised recruitment problems and we plan to run SAS Listening Events alongside with College staff and Council members. Please let us have your ideas and thoughts through our College email: sas@rcoa.ac.uk.

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SAS and Specialty Doctors

SAS UPDATE: SUMMER 2017

I write this as I enjoy a bit of unusual free time during August. The last major event attended by Dr Kirstin May and me was the ‘New to the NHS Day’ in July. This started as a day for MTI doctors who come to the UK to work and train for two years. We know that many SAS doctors are recruited from abroad each year and the meeting has been expanded to include them.

The College has run successful Listening Events for trainees and we are proposing to do this for SAS doctors this month in Newcastle.

References
National Institute of Academic Anaesthesia (NIAA)

Coming soon, the next RAFT national project!

DALES – Drug Allergy Labels in the Elective Surgical Population

The Research and Audit Federation of Trainees (RAFT) is an ever-growing body of anaesthetic trainees interested in research and audit, organised into regional trainee-led networks. We undertake large-scale projects that offer trainees the opportunity to gain research experience within the time and geographical constraints of training rotations. A key component of the RAFT ethos is that all collaborators are credited for their contributions in resulting publications.

RAFT’s first national project is iHypE (Intraoperative Hypotension in Elder patients). iHypE ran earlier this year and RAFT would like to thank all 198 participating centres for their gargantuan efforts in making it a success.

Following a competitive selection process, DALES (Drug Allergy Labels in the Elective Surgical Population) was chosen at the 2016 AAGBI GAT Annual Scientific Meeting to be the next national project. DALES aims to examine the prevalence, nature and impact of allergy labels in the UK surgical population. DALES also aims to promote the use of drug allergy labels for non-drug allergies and non-drug allergy labels for recognised side-effects (e.g. nausea with morphine, bradycardia with beta-blockers) or for non-drug allergic reactions (e.g. hay fever, dust allergy). They may even see use as a ‘patient alert system’ for non-allergic problems such as anxiety or needle phobia.

Whilst may be clinically relevant, they may cause harm if they lead to inappropriate avoidance of important drugs or use of more toxic and less-effective alternatives. A key example of this is ‘penicillin allergy’, second-line non-penicillin prophylaxis is known to be associated with increased rates of MRSA, VRE and C. difficile infection, longer hospital stays and higher re-admission rates. Labels must be deciphered by the anaesthetist, creating complexities and prescribing dilemmas, often on the day of surgery.

We aim to:

■ determine the prevalence and accuracy of drug allergy labels in the UK elective surgical population
■ determine the impact of penicillin-allergy labels on the administration of antibiotic prophylaxis
■ determine the impact of nonsteroidal anti-inflammatory drugs (NSAIDs) and opioid allergy labels on rates of unplanned overnight stays for painful day-case procedures
■ explore the impact of drug allergy labels on perioperative prescribing by anaesthetists.

DALES is being designed and delivered using the online Anaesthesia Audit system. It will be a three-day snapshot study with all adult patients attending for elective surgery considered for inclusion. Patient participation will consist of a primary questionnaire administered electronically on portable devices via Anaesthesia Audit. A subset of patients with allergy labels to penicillin, NSAIDs or opioids will undergo limited same-day follow-up. Anaesthetists of all grades will also be asked to complete a brief survey during the study period.

DALES has been presented at the BJA Anaesthetic Research Society meeting, GAT 2017 and HSRC and we are grateful to all bodies and individuals involved for their valuable feedback.

RAFT IT/IG Lead, Golden Jubilee Consultant Anaesthetist and Dr David Fallaha, Consultant Anaesthetist, Leeds Teaching Hospitals

Dr Caroline Thomas, Consultant Anaesthetist and RAFT Secretary, Leeds Teaching Hospitals

Dr Beverley Parker, ST7 Anaesthesia, Leeds Teaching Hospitals

Dr Sam Clark, ST7 and Chair of RAFT, Oxford University Hospitals NHS trust

Dr David Fallaha, Consultant Anaesthetist and RAFT IT/IG Lead, Golden Jubilee National Hospital, Glasgow

Dr Louise Savic, Consultant Anaesthetist, Leeds Teaching Hospitals on behalf of the DALES Steering Committee

References

We need your help!

Large-scale projects such as this rely on trainees contributing valuable time to collect data and consultants embracing the project and supporting their trainees in doing so. For more information, please visit www.rafrainees.com or email raftdales@gmail.com
**Shared decision-making in practice**

**Dr Chris Snowden and Dr Mike Swart, RCoA Perioperative Medicine National Clinical Leads**

‘Medicine is a science of uncertainty and an art of probability’

Sir William Osler

The first article of this series used a clinical vignette to show different perspectives on a decision to be made about surgery and outlined the need for shared decision-making in perioperative medicine (POM). This article outlines the key features of a shared decision-making consultation to explain how it differs from our usual style of consultation.

The shared decision-making consultation cannot occur alone, and must be supported by pathways which ensure it can be implemented, measured and embedded. There are three key components of a shared decision-making process:

- **Provision of reliable, balanced and evidence-based information outlining the treatment, outcomes and uncertainties**
- **Decision support to clarify options and preferences**
- **A system for recording, communicating and implementing the patient’s preferences**

There are also some fundamental requirements:

- **Space** for the patient and carers/relatives
- **Time**: a defined consultation time
- **As much information as possible** before you start – read notes and letters prior to meeting the patient
- **Minimal distractions** such as computers, bleeps
- **Written information** and/or decision aids if practical

**Setting the scene**

It is surprising how often patients have no idea why they are seeing you. It is useful to outline your understanding of the clinical problem and check with the patient that this aligns with their understanding. Hand the consultation to the patient and tell them it is their time to explore their options, ask questions, tell you their concerns and worries. Useful phrases are listed opposite.

**Closing the consultation**

**Recap what has been discussed, and if a decision has been made ensure it is documented in the patient’s notes. Offer to provide the patient with a copy of the clinic letter. Ensure the patient knows how to get in contact if they have further questions.**

**Summary and conclusions**

An article of this length cannot provide a comprehensive guide to these consultations: we have not mentioned difficult situations (for example, the patient who has unrealistic expectations or health beliefs or the patient who prefers a paternalistic approach). Face-to-face training in shared decision-making is better suited to this, and the RCoA are collaborating with Choosing Wisely to roll out training in 2018.

**Further reading**


**USEFUL PHRASES**

- This is your consultation. I want to check that you have all the information you need to decide on whether this type of surgery is right for you, and to help by answering any questions you may have.
- I am happy to give you my views on this but it is okay with you if I will describe the options to you so you understand the pros and cons of each, then we can consider what matters most to you.
- Can I just check that I have explained this well enough to you?
PERIOPERATIVE JOURNAL WATCH

Dr Katie Samuel, Dr Andrew Selman and Dr Bence Hajdu, Perioperative Medicine Fellows, University College London Hospitals

**Cohort study of preoperative blood pressure and risk of 30-day mortality after elective non-cardiac surgery**

Preoperative blood pressure is always a popular topic of discussion. This large UK cohort study looked at over 250,000 patients over 10 years using primary care data from the UK Clinical Practice Research Datalink, investigating the relationship between preoperative BP and 30-day mortality after non-cardiac surgery. Just over 2.2% (5899) patients died within 30 days, with low preoperative BP in the elderly sub-group being consistently associated with increased odds ratio of death. Risk thresholds started at pressures of 119/63.


**Preoperative haemoglobin levels and iron status in a large multicentre cohort of patients undergoing major elective surgery**

This Spanish multispecialty group conducted a multicentre retrospective observational cohort study, with the aim of elucidating the prevalence and causes of preoperative anaemia to help plan preoperative IV iron services. Looking at over 30,000 patients, they found that a third were anaemic, with the highest prevalence in colorectal and gynaecological patients, with the majority having absolute iron deficiency. Of those identified, all would have benefited from preoperative iron supplementation with or without erythropoietin. They also noted that over half of non-anaemic patients also had absolute iron deficiency at low stores, and would also benefit from iron supplementation. Of note, the lead author Muñoz was involved with the recently published international consensus statement on the perioperative management of anaemia and iron deficiency, from which their guidance on treatment was taken. Muñoz M et al. Anaesth 2017;72(7):826–834. http://doi.org/10.1111/anae.13940

**Levosimendan in patients with left ventricular dysfunction undergoing cardiac surgery**

This was an international multicentre, randomised, placebo-controlled trial evaluating the efficacy and safety of levsimendan in patients with a left ventricular ejection fraction of 35% or less, undergoing cardiac surgery with cardiopulmonary bypasses. They had two primary end points: a four-component composite of death at 30 days, renal replacement therapy at 30 days, perioperative myocardial infarction at Day 5, or use of a mechanical cardiac assist device at Day 5, and a two-component composite of death at 30 days or use of a mechanical cardiac assist device Day 5. The study failed to show any benefit in using levsimendan or difference in rate of adverse events. Mehta RH et al. JAMA Surg 2017 https://doi.org/10.1001/ jamasurg.2017.2898

**Using data to enhance performance and improve quality and safety in surgery**

A significant proportion of adverse events that happen within hospitals do so in theatre. A team in Canada developed and tested a multport synchronised data capture and analytical platform called the ‘Black Box’. It collects intraoperative data, patient physiological data, video recordings of the theatre, laparoscopic and robotic cameras, video laryngoscopy, as well as wearable cameras during open surgery. The data is stored securely, and is hoped to be used to improve the technical and non-technical skills of surgeons. It is an evolving trial in ten centres across North America, South America and Europe. Goldbergen M et al. JAMA Surg 2017 https://doi.org/10.1001/jamasurg.2017.2898

**Guidance and other resources on returning to practice**

Since the launch of revalidation in December 2012 we have offered a revalidation helpdesk service via revalidation@rcoa.ac.uk for responsible officers, appraisers and doctors who are seeking specialty advice. Many of the enquiries received can be dealt with very rapidly by the College Revalidation and CPD team – for example, questions about supporting information categories and how a doctor can check their revalidation date. However, questions which require clinician input need to be put in writing and are then anonymised and referred to a revalidation specialty adviser(s) for a detailed response.

Over the last couple of years, the majority of enquiries received by the helpdesk have been about continuing professional development (CPD) requirements and the appraisal process, followed by a large number of enquiries about returning to practice after a period of absence.

It is expected that many doctors will want to take career breaks within their revalidation cycle (for example, maternity leave or study leave) and there is flexibility in the process to manage short-term absences. Some of the supporting information is required once every five years rather than annually, although doctors are advised to try and keep their CPD in their clinical areas up to date – even if they are not actively practising (this can be done through e-learning or journal reading), and a ‘return to work’ appraisal may be required by the doctor’s employer.

Whether a longer period of absence is ‘significant’ will be a matter of judgement based on such considerations as the doctor’s amount of time in practice before having a break, and their job plan and its content, whilst the revalidation process allows for the doctor’s responsible officer to recommend a deferment of their revalidation to the GMC in order for any gaps in supporting information to be addressed.

We have been working with the Academy of Medical Royal Colleges to develop updated guidance on returning to practice. This, plus further resources to assist with this very important topic, are available in the Revalidation Guidance section of our website: www.rcoa.ac.uk/revalidation

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**Chris Kennedy, RCoA CPD and Revalidation Co-ordinator**

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The RCoA is committed to developing a collaborative programme for the delivery of perioperative care across the UK: www.rcoa.ac.uk/perioperativemedicine
NELA: THE THIRD REPORT

October 2017 saw the release of the third patient report of the Healthcare Quality Improvement Partnership (HQIP) commissioned National Emergency Laparotomy Audit (NELA). NELA has been collecting data on patients in England and Wales undergoing emergency laparotomy surgery since 2012.

Between December 2015 and November 2016, hospital staff entered data on almost 25,000 patients (over 80% of all emergency laparotomies) across 187 hospitals. This third report also includes the second NELA organisational audit from October 2016 which provides us with information on how hospitals are organising their emergency anaesthesia and surgical services and whether this meets national standards.

Key messages from the report
The 30-day mortality after emergency laparotomy (EL) surgery has fallen from 11.8% to 10.6% over the three years that NELA has been reporting, representing a marked difference in their length of stay and a significantly higher 30- and 90-day mortality after EL surgery. It is clear from other patient cohorts (hip fracture for example) that input by consultant-led care for high-risk patients.

Overall, the number of hospitals meeting standards of care, such as risk assessment before surgery, consultant anaesthetist and surgeon presence in the operating theatre for high-risk patients (where predicted risk of death is above 3%), and CT reporting preoperatively. These improvements in care are alongside the findings of positive changes in infrastructure that hospitals provide for patients who need emergency bowel surgery. These include an increase in the 24/7 emergency operating theatre capacity, more pathways and protocols for care of EL patients and working patterns that support the delivery of consultant-led care for high-risk patients. Overall, the number of hospitals meeting the nine key standards has improved since the beginning of NELA from only 3.5 to almost 5 out of 9.

One of the key messages of our previous reports was to encourage the use of tools, such as P-Possum (physiological and operative severity score for the enumeration of mortality and morbidity), to estimate an individual patient’s risk of death from the emergency surgery they require. This has now been supplemented by a bespoke NELA risk score available online (http://www.NELA.org) and as an app. We also recommended that the quality of care and outcomes for patients can be improved by planning and providing care that is appropriate for each patient’s predicted risk (see Box 1). This report shows that there has indeed been an increased use of protocols and pathways to ensure care is provided for patients according to their risk of death. Of crucial significance for patients, there has been a large improvement in the proportion of high-risk (predicted mortality >5% and 10%) patients admitted directly to critical care after surgery.

However, the data also finds that there is still significant variation in standards of care between hospitals and even within the same hospital depending on, for example, the time of day surgery is performed. These inconsistencies inform the areas of potential improvement that are required to ensure that patients receive the same high-quality care for their emergency laparotomy surgery wherever, and whenever, they need it.

Box 1 Planning for and providing appropriate care: recommended protocols

- CT scan reported before surgery?
- Risk of death documented preoperatively?
- Arrival in theatre in timescale appropriate to urgency?
- Preoperative review by a consultant surgeon and anaesthetist when P-Possum risk of death >5%?
- Consultant surgeon and anaesthetist both present in theatre when P-Possum risk of death >5%?
- Consultant anaesthetist in theatre when P-Possum >5%?
- Consultant surgeon in theatre when P-Possum >5%?
- Admission directly to critical care after surgery when risk >10%?
- Assessment by geriatrician for patients over the age of 70?

One particularly consistently poor-performing area of care that needs addressing is the provision of specialist geriatric care for patients over the age of 70. This group of patients have a marked difference in their length of stay and a significantly higher 30- and 90-day mortality after EL surgery.
NELA, quality improvement, quality assurance and research

NELA is not simply a data-collection tool. We aim to provide the bedrock of data that is crucial in driving improvement in care for this high-risk group of patients. NELA data is readily available via our website for use by local clinicians, managers and commissioners to support quality improvement and quality assurance. These include dashboards (http://bit.ly/2hAG2yp) and publicly available quarterly reports (http://bit.ly/2hAG2yp). The latter are produced within two weeks of the end of each quarter’s data-collection window, and so provide timely feedback on hospital performance that can be circulated to hospital management to support efforts to improve care.

It is this improvement work, often involving multidisciplinary clinical and non-clinical teams, that will be fundamental in continuing to drive up standards of care for EL patients. NELA supports this by making recommendations to commissioners and CEOs that they must support QI work, and provide funded time for clinicians and other staff, and investment if they are to realise sustainable improvements.

There still remain questions regarding the best methods to care for such a heterogeneous group of complex emergency surgical patients, and NELA data is being used in regional and national studies such as Elf (emergency laparotomy and frailty), Alpine (adaptation of lung protective ventilation in patients undergoing emergency laparotomy) and FLOELA (fluid optimisation in emergency laparotomy).

**Box 2** Candidate process measures for a best-practice tariff (to be consulted upon)

I. Assessment of risk.
II. Timeliness of access to theatres.
III. Consultant presence in theatres.
IV. Admission to critical care.
V. Input by specialists in the care of older people.

What next for NELA and EL patients?

As the audit moves forward into its fourth year, we are delighted that the RCoA will retain the contract to deliver NELA on behalf of HQIP. A best-practice tariff is being developed for 2019 that aims to incentivise delivery of high-quality care. Candidate measures are shown in Box 2. There is still much work to be done to improve care for EL patients, and anaesthetists have a pivotal role in leading towards achieving this. We thank all the local clinical leads who have worked hard to ensure not only the submission of high-quality data but also the many innovative quality-improvement projects which have led to reduced mortality and improved outcomes. The next step for NELA will be to become more patient-facing and engaging and collaborating with families and patients to shape the care that they want to receive. After all, every dot of data on these ruchcharts represents a patient – a mother, father, son or daughter – each with unique needs for whom we must strive to provide the best possible care we can.

Significantly improving outcomes for patients was built from a combination of deep clinical knowledge and highly evolved teamwork. This clinical knowledge comes from both the experience of working in NHS and military hospitals, and from education in the underlying trauma principles. Principles of ballistic injury are both taught and researched using items such as gelatine blocks. Gelatine is used to represent human tissue in ballistic research. Using high speed cameras to film the events that occur when gelatine is struck by high energy projectiles (such as bullets) and analysing the results, injury patterns can be understood and treatment protocols designed. The teamwork comes from many rehearsals in simulated training environments.

The clinical protocols are summarised in accessible books such as Clinical guidelines for operations [CGGs] (JSP 999) (http://bit.ly/2b9BCG) and delivered on courses such as the Battlefield Advanced Trauma Life Support course (BATLS).

**ARIES Talk**

**GELATINE AND SILICONE**

Colonel Peter Mahoney’s ARIES Talk Gelatine and Silicone explains how, during the recent Afghanistan conflict, the UK-led field hospital at Camp Bastion achieved remarkable clinical outcomes for very severely injured patients.

Battlefield casualties often have very complex injuries. Effective treatment and management of these injuries demands a combination of resuscitation, surgery and pain management. Effective pain management in Camp Bastion included using regional anaesthesia. Safe placement of regional anaesthesia catheters and injections is achieved by using ultrasound machines. This means that battlefield anaesthetists need to be familiar with all these techniques and delivering them in austere conditions.

The Royal Centre for Defence Medicine (RCDM) is exploring new ways of providing robust training to prepare people for deployment. Current projects include developing very realistic silicone rubber-based human models with internal organs (Trauma FX Ltd and Nottingham Trent University) to train management of complex trauma in field conditions. In addition, with Birmingham University, virtual reality scenarios are being created to simulate the aviation environment of the helicopter-based Medical Emergency Response Team. Combining these two approaches will offer a very adaptable solution to prepare future clinical teams to care for combat casualties.

![Colonel Peter F Mahoney CBE QHS Emeritus Defence Professor Pictured in Afghanistan, 2007](http://bit.ly/ARIESmahoney)
Undergraduate teaching in anaesthesia, critical care, pain and perioperative medicine

The RCoA is writing its own framework to guide teaching of undergraduates. As part of this, we conducted the first comprehensive survey of undergraduate teaching in all UK medical schools in anaesthesia, critical care, pain and perioperative medicine (POM) to assess how many of them have formal programmes in these subjects.

What we did
The Perioperative Medicine Undergraduate Curriculum Sub-Group Committee met to agree the content and structure of the survey, focusing on items relevant to the GMC document Outcomes for Graduates and what the committee thought medical students would reasonably be ‘exposed to’ during undergraduate placements. We used a telephone survey to ensure a high response rate, and to fully record free-text responses.

The survey consisted of nine key open questions (Table 1). We targeted leads for undergraduate teaching in ‘anaesthesia’ from all UK medical schools in interviews between February and November 2016. ‘Anaesthesia’ was taken to mean clinical anaesthesia, critical care, pain and perioperative medicine.

Our key findings
We received responses from all 33 UK medical schools. Teaching is predominantly consultant led. ‘Anaesthesia’ is integrated into the undergraduate curriculum in three main forms:

- In an acute care block, with emergency medicine and acute medicine
- In a surgical block
- In a few schools, it is part of a block termed ‘perioperative medicine’

Fifty-two percent of medical schools have written their own discrete curriculum or objectives for time spent in ‘anaesthesia’. Not all UK medical schools have allocated core undergraduate time in our specialties (Table 2).

Of the medical schools surveyed, 31 out of 33 could quantify the total time spent in ‘anaesthesia’. The median time was 80 hours (range 16–200 hours) during their entire course.

Ninety percent of medical schools offer a student-selected component in anaesthesia, critical care or POM. But other opportunities for undergraduates to gain more experience are more limited: only 27% of medical schools offer an intercalated BSc in these areas.

Many interviewees had ideas as to how we could improve undergraduate teaching (Table 3).

Our reflection
Anaesthetists are delivering a huge amount of innovative teaching to medical undergraduates. Many anaesthetists and intensivists already hold senior positions within medical school hierarchies, as heads of years, heads of programmes, and indeed as dean.

Anaesthetists, intensivists and pain doctors are thinking less rigidly about their own subjects as limited super-specialised areas. Many are using the surgical patient to teach examination and history taking, resuscitation skills, ethics and the law, data interpretation, care of the deteriorating patient, and teamwork.

There are large differences in time given to anaesthesia, critical care, pain and POM between UK medical schools. Our own institution, for example, does not have any core allocated time for undergraduates in critical care, but we are not alone.

Many suggested that the RCoA should resist the temptation to issue a detailed, complex curriculum, but focus on generating a network of undergraduate trainers, a central source of electronic resources, and acting as an ‘undergraduate educator’ to raise the profile of the role of anaesthetists.

Table 1 The nine key areas explored in the survey

| Demographics of your medical school |
| Tell me about your teaching of undergraduate ‘anaesthesia’ |
| How is ‘anaesthesia’ taught? |
| Who delivers the teaching? |
| How much teaching is there? |
| Is ‘anaesthesia’ assessed and how? |
| Are there Special Study Modules, Electives or Degree Courses offered? |
| How could the teaching of undergraduate ‘anaesthesia’ be improved? |
| How could the RCoA help? |
The John Snow Awards are an exciting opportunity for medical students interested in anaesthesia and its related disciplines and undertaking an intercalated bachelor’s or master’s degree. Students can compete for funding and kickstart their future academic careers. The awards have been running and administered by the National Institute of Academic Anaesthesia (NIAA) since 2013. To date, 37 awards have been made to a total of £73,000.

The 2017 John Snow Awards winners are students from a range of institutions, carrying out research studies covering a wide variety of topics. More information on this year’s winners is available here: http://bit.ly/johnsnowawards.

In 2018, there will be up to 14 awards available in total: up to 13 for £2,000 each funded by AAGBI/Anaesthesia and the RCoA/BJA. One award will be funded by the Neuro Anaesthesia and Critical Care Society of Great Britain and Ireland (NACCSGBI) for £1,000. Awards are for one year and are given to the successful students to contribute to living costs. Project running costs will need to be met by the student’s supervisor or institution.

If you know of or are supervising a student who is thinking of undertaking an intercalated BSc or MSc in anaesthesia or a related subject in 2018, advise them to start planning early. Some funders will not consider students that have already started their intercalation.

Look at last year’s rubric as it is unlikely to change much.

Look at previous successful applications here: http://bit.ly/2hBUqGy

If the project is going to take two years, ensure we know how it is going to be funded. This should be made clear in the application form.

Table 2: Is time in anaesthesia, critical care, pain and POM core to the undergraduate curriculum in UK medical schools [%]

<table>
<thead>
<tr>
<th>How is anaesthesia taught?</th>
<th>% UK Medical Schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core to ALL undergraduates</td>
<td></td>
</tr>
<tr>
<td>Anaesthesia</td>
<td>97</td>
</tr>
<tr>
<td>Critical care</td>
<td>82</td>
</tr>
<tr>
<td>Pain</td>
<td>55</td>
</tr>
<tr>
<td>Perioperative medicine</td>
<td>24</td>
</tr>
</tbody>
</table>

Table 3: Summary of answers: ‘How could we improve undergraduate teaching in anaesthesia, critical care, pain and POM?’

Learning content and resources

■ ‘Flip’ the learning: have YouTube and other online material
■ Have a clear syllabus, curriculum and objectives: especially in-theatre time
■ Simulation – resource heavy but the students love it!
■ Teaching ‘jacks’ in each theatre, e.g. cases scenarios
■ Run a session of Single Best Answers to consolidate core knowledge
■ Share teaching resources between medical schools
■ Teach ICU and care of the patient having surgery – not lots of anaesthesia details

Organisation

■ Get students to do ‘on-call’ with the emergency anaesthesia team
■ Clarity of financing of PAs or SPAs for teachers
■ Students shadow named trainees and consultants
■ Start an undergraduate anaesthesia society
■ Increase our early-years medical school teaching, e.g. anatomy teaching using ultrasound
■ Increase pain teaching: ward rounds with nurses and the educational performance measure scheme
■ Integrated emergency medicine and ICU weeks

Assessment

■ Make sure our subjects are examined in medical school exams
■ Assess them in new ways, e.g. a portfolio

Acknowledgments

We wish to thank the respondents who kindly gave their time and RCoA Committee members who devised the survey.

References

‘Between a rock and a hard (work) place?’

Musings of a jobbing anaesthetist on the RCoA Council

Dr Krish Ramachandran, RCoA Council member and Chair of the Equivalence Committee

I confess, I am not looking forward to retirement – the point of no return. It’s in the offing in a few years’ time and I am dreading it, just a bit. Fears about boredom, rising cost of living, and not to mention the cost of raising our offspring, who are still in school, consume me.

It was in one of those troubled moments that I chanced upon a weekend publication of some repute. No sooner had I read the headlines on page 8, I felt relieved. It said, ‘Want a longer, happier life? Retire later.’ Which publication? You ask. Waitrose Weekend (WW) no less. WW commissioned a survey (not scientific, I agree), and declared 63 as the new perfect age for retirement. Boredom, loneliness and income were the reasons cited by the participants for putting off retirement. I don’t know about you, but I rate Waitrose folk as well-heeled and discerning, who occupy the top rung of the much-vaunted social hierarchy. As a Sainsbury’s shopper, and desperately clinging on to the rung below, I am looking for a leg up. So, when my sentiments closely aligned with those native to the upper crust, I felt the warm embrace of haute society, momentarily.

Frivolity aside, there is a serious underlying message in the foregone passage: that with a steady increase in life expectancy, concerns about loneliness, boredom and perhaps poverty in later life are likely to escalate further. So, working to 65 and beyond may well become the norm in many sectors in the next few decades.

If a section of society is happy to work beyond the age of retirement, why is a significant proportion of the medical workforce ready to throw their towel in early? Surveys by the British Medical Association and the Hospital Consultants and Specialists Association amongst others point out that GPs are suffering from burnout and low morale, levels of which are both at an all-time high. The results are applicable to those in secondary care too, as hospital environments are becoming increasingly more stressful. As a profession, we consistently top the charts in terms of user satisfaction: shouldn’t job satisfaction be high too? Evidently not: consumer satisfaction does not translate to job satisfaction. There are reasons aplenty for the low morale and these are well known. This is further compounded by an extended working life, with the retirement age being put back to 65 and beyond. Anaesthetists who are expected, or indeed compelled to work beyond the age of 60 face unique challenges which can adversely impact their clinical performance. These include a decline in reflexes and cognitive function, made worse by lack of sleep and fatigue. This subject is discussed at some length in the August 2016 issue of the AAGBI newsletter: Age and the anaesthetist [see http:/ /bit.ly/2kCnSti].

If seniors are disillusioned with the work environment, what hope do our junior doctors faced with long careers ahead have? This is well illustrated by the RCoA trainee survey from which a full report will be published in November or December. The preliminary results of which are quite telling [http:/ /bit.ly/2x22bYB]. It reported that 85% are at risk of becoming burned out. Long hours, concerns over patient safety, the disruption of working night shifts and long commutes were identified as key reasons for growing fatigue and disillusionment.

Is there a solution?

There are no simple answers. As a first step, management and the medical profession must acknowledge the ever-widening division between themselves, and efforts must be made to heal the rift. There is some evidence on the ground that this is already happening. Secondly, gaps in service provision, a major reason for stress at the work place, must be plugged as a matter of urgency. Retiring doctors are a temporary solution, but for reasons alluded to, cannot be expected to work at the coalface after retirement. Thirdly, whilst NHS management has been quick to adopt industry models to replicate efficiency, it hasn’t demonstrated the same enthusiasm in embracing some of the proven strategies that promote the health and wellbeing of its staff, critical for increasing productivity.

For its part, the RCoA has been working full throttle by publicising the many issues through its website, skilfully exploiting the media and engaging with politicians from all sides. But, I believe it can do more: it can, for example, identify the departments and schools where morale is high and use them as exemplars of good practice. It can, for example, identify the departments and schools where morale is high and use them as exemplars of good practice.

Juxtapose the contrasting results of the surveys, and you will notice a clear message emerging: ‘Retirement is not fun, but an intolerable work place environment is worse’. So, politicians and employers please take note: ‘A happy workforce is a productive workforce, and consequently a more satisfied customer base – not the reverse.”
The flame burnt brightly in the lamp carried by Florence Nightingale as she tended to the sick and wounded during the Crimean War.

The flame consumed oxygen from the air: a highly reactive and yet life-sustaining gas. The ‘lady with the lamp’ as she became known had not only established the foundations of hygiene and asepsis in those days, but through the use of statistical tools, possibly also of evidence-based medicine.1 One hundred and sixty-two years later the World Health Organisation (WHO) picked up the torch, leading in the fight against surgical site infections (SSIs). In 2016, WHO published guidelines aimed at curbing the plague of SSIs.2 In 2016, WHO published guidelines aimed at curbing the plague of SSIs.3 The recommendation is graded as ‘strong’ and based on moderate quality of evidence drawn from a meta-analysis of the 11 randomised studies indicating benefit without harm. It stands in contrast to work by Wettelev and others who, while confirming benefit in terms of SSI prevention (very low-quality evidence) caution against the risk of adverse events including mortality.4

What are the risks?
Oxygen use as an antibiotic agent is well established and exemplified by the hyperbaric oxygen therapy with indications including necrotising soft tissue infections, osteomyelitis and clostridial myositis. There is, however, increasing appreciation of harm of oxygen both from free radical-mediated damage – which has been likened to radiation toxicity – and from its physiological effects on respiratory and cardiovascular systems. High FiO2 can cause alveolar septal injury, pulmonary capillary leak syndrome and promote lung fibrosis. In the heart, we see increased coronary vascular resistance, a decrease in coronary blood flow and cardiac index. Recent work shows association of high FiO2 with increased myocardial infarct size and worse outcomes after stroke and cardiac arrest. Paediatricians are well aware of its association with retinopathy and blindness of prematurity and often resort to air when resuscitating newborn babies. It is clear that while the absence of oxygen is harmful, this does not automatically mean that excess is beneficial. Aside from long-term oxygen therapy in COPD, there is little evidence of impact of oxygen on mortality. It is possible that we delude ourselves about its benefit in other disorders.4

Proceeding with caution
Our understanding of public health, infection control and human physiology has evolved since the days of Florence Nightingale. Through the application of stringent statistical analysis, evidence-based medicine has been forged: and it is beginning to inform clinical practice. Trial evidence, however, needs to be interpreted vis-à-vis biology and the indiscriminate application of what is a potentially toxic gas should be carefully considered before harm is caused.

References

It is clear that while the absence of oxygen is harmful, this does not automatically mean that excess is beneficial.
REMOTE AND RURAL MEDICINE
An emerging opportunity for anaesthetists?

Dr Andrej Andrasovsky,
Consultant Anaesthetist and Director of Dr Gray’s International Airway Day, Dr Gray’s Hospital, Elgin, Moray

Remote and rural medicine and advanced airway management can go hand in hand as a new exciting and emerging teaching opportunity for anaesthetists with a flair for adventure.

There is a widely accepted mantra that advanced airway management belongs uniquely in the hands of anaesthetists, thus placing them at the forefront of teaching in the field of acute medicine. Teaching primarily takes place in large university teaching hospitals. However, once we start looking beyond the needs of large academic centres, we discover that there are vast and uncharted teaching opportunities for anaesthetists in remote and rural areas.

Let’s imagine a remote hospital in the dead of winter with deep snow and ice, treacherous roads, surrounded by mountains or sea, and a clinical emergency attended by only one senior clinician such as an anaesthetist. In such a situation, a clinician has to rely on the help of people immediately to hand: predominantly foundation doctors, nurses and paramedics. When a patient’s life is at risk and time is precious, there is no time to wait for senior help to arrive. Telemedicine and other perks of modern technology are widely promoted, but clearly cannot replace direct hands-on skills and expertise in emergency situations. The only way to save the patient is to teach everyone involved. This vulnerability creates a weak link which causes repetitive crises. In such a working environment, it is very easy for the whole team to become overwhelmingly demoralised thereby creating further staff losses and spiralling into disaster.

One way to fight the blues of remoteness and isolation is by boosting the morale of healthcare practitioners by enhancing their clinical expertise and practical skills as a multi-professional team. Every team member needs to know their role and how to respond to clinical emergencies. By teaching highly professional and technical skills among all emergency personnel, one can make a significant positive contribution to the morale of all healthcare workers. Everyone must feel that they can trust each other and be confident in the safety of their working environment.

Sharing learning: advanced airway workshops

To promote safety and good medical practice in remote locations, regular advanced airway workshops were organised by Dr Gray’s Hospital, a small district general hospital in the north of Scotland. Dr Gray’s International Airway Day was first held on 25 June 2016 and again on 10 June 2017 in the new state-of-the-art conference venue, the Alexander Graham Bell Centre at the University of the Highlands and Islands in Elgin. Workshops were primarily tailored for foundation doctors with no clinical experience, anaesthetic and recovery nurses, operating theatre nurses, accident and emergency staff, and paramedics. Delegates came from across the whole north of Scotland from as far as Shetland and the Western Isles.

The workshop delegates were taught by nationally and internationally renowned faculty lecturers, including past president and secretary of the European Airway Management Society and Difficult Airway Society Dr John Henderson, and Dr Jairaj Rangasami, Dr Subrahmanyan Radhakrishna, Dr Kemal Tolga Saracoglu and many other highly experienced international airway experts that teach at similar advanced airway workshops worldwide. Every delegate had ample time to practise with a variety of supraglottic airway devices, videolaryngoscopes, oral and nasal fibreoptic intubation and an array of advanced airway techniques. A separate workshop station was provided for surgical cricothyroidotomy on animal models and manikins.

What did we learn?

By teaching these advanced anaesthetic techniques to such a diverse group of healthcare professionals we achieved our goal of improving our hospital out-of-hours safety profile by retraining a vast majority of operating-theatre nursing staff in Dr Gray’s Hospital. Human factors and awareness of critical situations by multi-professional teams is critically important in creating the same mindset as to how to resolve time-sensitive emergencies. This advanced training also provided all levels of staff with a deeper insight into what anaesthetists were trying to achieve – and gave all team members a huge sense of job satisfaction. This self-satisfaction and professional development is crucial in boosting team morale and safety of the work environment in remote rural settings.

When a patient’s life is at risk and time is precious, there is no time to wait for senior help to arrive.
Restorative virtual environments for rehabilitation on the ICU

Early rehabilitation following critical illness aims to shorten time to independent ambulation and accomplishment of activities of daily living, prior to discharge to a general ward. Barriers to effective rehabilitation include patient compliance, motivation, pain and fatigue.

The uses of interactive technology-based systems, from video games to virtual reality (VR), have been explored in varied acute hospital settings. The use of such technologies is a challenge in intensive care units (ICUs). Commercial off-the-shelf (COTS) systems, such as domestic gaming consoles, may be unusable by those with the physical and cognitive consequences of critical illness. These systems and games may also be unsuited to delivering recovery-related interventions. Bespoke systems have been developed for other patient groups, but these are often expensive and demand patient transfer to the device.

With prior experience of using VR in varied healthcare settings, the Human Interface Technologies (HIT) team at the University of Birmingham are collaborating with the Defence Medical Services and the Queen Elizabeth Hospital Birmingham Critical Care Research Group. Combining their expertise in human-centred design (HCD) and early rehabilitation on the ICU with their enthusiasm for innovation, they have developed a number of prototype virtual reality-based systems, combining COTS hardware with bespoke virtual environments. Feasibility studies of these prototypes have formed the Restorative Virtual Environments for Rehabilitation (REVERE) Programme, evaluating their use as a distraction for patients during burns dressing changes, to enhancing sleep in the ICU, and enhancing performance during incentive spirometry and recumbent cycling.

REVERE aims to
- Develop prototype devices that provide or enhance interventions with an established evidence base, or that are part of clinical practice at QEHB, such as incentive spirometry following major upper gastrointestinal surgery and recumbent cycling as a physiotherapy adjunct for ICU-acquired weakness.
- Develop the methodology to rigorously evaluate the technologies, combining early bench testing with an iterative design process with clinical trials in patients.

Using an HCD process and guided by a usability engineering process, clinical, patient and engineering stakeholders will define the precise user requirements of the device. These specifications include the required intervention or gaming ‘rules’ such as ‘what constitutes a deep breath’ as well as the environment and capabilities of the patients and staff. Repeating this process has led to a shared learning of clinical language and nuance for the engineers and greater precision and clarity from the medics.

The REVERE prototypes have used Virtual Wembury – a three-dimensional reconstruction of the South Devon coastal path, as the VE backdrop. Within Virtual Wembury, the HIT developers have introduced functionality for each project, including a sunset, speedboat game, virtual hebusket and recumbent bicycle.

Early evaluation of components – from hand controllers to visual displays – is being done via bench/laboratory testing and then demonstrated to staff focus groups and the QEHB ICU for patient testing, the prototype is then demonstrated to staff focus groups and the QEHB ICU patient and public involvement (PPI) representatives prior to integration into the system. Once the system has reached the required maturity for patient testing, the prototype is used as the basis for a clinical trial.

The clinical effectiveness of the device, and also to define how it has been used via embedded usage software and video capture, as well as patient/staff questionnaires. Such information clarifies how well each intervention works and whether it is fit for purpose, which will then feed into the future development of the device.

Rapid technology evolution means time-consuming processes and permissions are required for clinical device trials, which may render systems obsolete by the time they are tested. So it is essential to understand what works where and for whom, to allow effective horizon scanning of novel technologies and early, appropriate integration into clinical care.

References

For further information please follow @RevereTrials on Twitter.
In pursuit of a shared international perioperative medicine curriculum

In order to improve the care for surgical patients, the core components of perioperative care have been identified, and the importance of a shared, evidence-based curriculum is widely accepted.

The development of a shared international curriculum for perioperative medicine is a major goal of the International Perioperative Medicine Curriculum Working Group. This group aims to create a curriculum that is internationally agreed upon and can be used to train perioperative medicine professionals.

The curriculum will be based on the principles of quality care, patient safety, and evidence-based medicine. It will be developed in collaboration with experts from around the world, and it will be available online for free.

The curriculum will be divided into modules, each covering a specific aspect of perioperative care. The modules will be designed to be self-contained, so that learners can choose which modules to study and in what order.

The curriculum will be continually updated and revised, based on the latest research and clinical evidence. It will be available in multiple languages, so that it can be used by perioperative medicine professionals worldwide.

The International Perioperative Medicine Curriculum Working Group is an international collaboration of experts in perioperative medicine, including surgeons, anesthesiologists, and critical care physicians. The group is sponsored by the International Society for Clinical Perioperative Research (ISCP) and the Royal College of Anaesthetists (RCoA).

The group is made up of representatives from all over the world, including North America, Europe, and Asia. The group meets regularly to discuss the development of the curriculum and to ensure that it meets the needs of its users.

The group is committed to making the curriculum accessible to all perioperative medicine professionals, regardless of their location or level of experience. It is hoped that the curriculum will help to improve the quality of care for surgical patients worldwide.

References
4. Evidence Based Perioperative Medicine website (www.ebpom.org ).
12. Duke School of Medicine joins with University College London on perioperative medicine initiative (http:/ /bit.ly/2y3Fly4).
A quick guide to the NIHR CRN portfolio

Ms Sian Birch, Senior Research Nurse, Anaesthesia Critical Care Emergency and Trauma, King’s College Hospital NHS Foundation Trust

Ms Clair Harris, Matron, Anaesthesia Critical Care Emergency and Trauma Research Lead, King’s College Hospital NHS Foundation Trust

The National Institute of Health Research (NIHR) was initiated and founded in 2006 by Professor Dame Sally Davis, Chief Medical Officer and is now led by Professor Chris Whitty, Chief Scientific Adviser at the Department of Health. It is funded by the Department of Health in order to improve health and wealth through research in England. The NIHR invests more than £500 million a year in research infrastructure in the NHS, of which the Clinical Research Network (CRN) is the largest element. The NIHR CRN can be considered as the research delivery arm of the NIHR.

Workforce and structure

The NIHR CRN coordinating centre manages the CRN on behalf of the Department of Health. The CRN is divided into 15 local CRNs in England, and these local networks coordinate and support the delivery of portfolio studies in the NHS in England. It supports clinical research in 3D clinical specialties, with the CRN executive team overseeing six specialty cluster leads, based in five partner universities (Leeds, Liverpool, Newcastle, Imperial and King’s College London). Anaesthesia, perioperative medicine and pain management (APM&PM) is one of the 30 specialties, led nationally by Professor Mike Grocott, and Professor Stephen Smye OBE, who is the NIHR CRN lead for four specialties including APM&PM, and based at KCL. Each of the partner universities has responsibility for improving the delivery of research in a number of crosscutting areas of science. KCL leads on imaging, genomics and experimental medicine and has contributed to other topics including big data and medical technology. For example, a recent report on medical technology in anaesthesia has been published jointly with the RCoA based on a workshop held at the RCoA and an ambitious plan to develop imaging research has also just been published following a stakeholder workshop. Each of the 15 local CRNs is led by a clinical director and their primary role is to fund the NHS service support costs for conducting high-quality research trials, which are funded by research partners in the NHS (these studies comprise the CRN portfolio). The criteria for studies being eligible to receive portfolio support are set out on the NIHR website. The local CRNs are tasked with ensuring the NHS has sufficient clinician and research nurse capacity to deliver the national portfolio and this is also an important element in the work of the specialty clusters. In order to engage the national anaesthetic clinical research community, the APM&PM CRN works closely together with the National Institute of Academic Anaesthesia (NIAA) and its associated research institutions.

Performance

The latest NIHR CRN review from the last financial year showed that:

- the highest-ever number of participants was recruited into the NIHR CRN portfolio with overall 667,000 participants, which is 10% higher than the previous year
- recruitment to time and target in non-commercial studies was 83% of all NHS trusts in the UK, 99% recruited into NIHR portfolio studies and 79% of all trusts recruited to commercial contract studies.

In 2016, KPMG published a financial performance and impact assessment of the NIHR CRN. It was estimated that in the financial year 2014/2015, the CRN supported research activities resulted in £2.4 billion of gross value added (GVA), plus the creation of almost 39,500 jobs in the UK. In addition, the NHS cost savings, as a result of the economic impact of clinical research activity, were about £192 million.

National awards

The RCoA and NIHR CRN Clinical Research Prize is awarded once a year in order to recognise outstanding contributions by NHS consultants and trainees in APM&PM. This highly prestigious award aims to further support NHS anaesthetists in APM&PM conducting clinical research.

In summary, the NIHR CRN has gone from strength to strength, with exceptional growth and excellent performance in the APM&PM. The APM&PM CRN provides a highly innovative and inspirational hub, embracing future themes with rapidly growing potential such as artificial intelligence/big data and the impact of next-generation genetic methods.

References


The 15 LCRNs in England

1. North East and North Cumbria
2. North West Coast
3. Yorkshire and Humber
4. Greater Manchester
5. East Midlands
6. West Midlands
7. West of England
8. Thames Valley and South Midlands
9. Eastern
10. Kent, Surrey and Sussex
11. Wessex
12. South West Peninsula
13. North Thames
14. South London
15. North West London

Dr Gudrun Kunst, Consultant Anaesthetist, King’s College Hospital NHS Foundation Trust

November 2017
NIAA RESEARCH GRANTS
Results of 2017 Round 1

On Tuesday 27 June 2017 the NIAA grants committee met to consider the first round of applications for 2017 on behalf of AAGBI and Anaesthesia/Wiley, the Association of Paediatric Anaesthetists of Great Britain and Ireland (APAGBI), BJA and RCoA, the Difficult Airway Society (DAS), the Obstetric Anaesthetists’ Association (OAA), and the Vascular Anaesthesia Society of Great Britain and Ireland (VASGBI).

The committee considered 37 applications over nine categories for a requested sum of £1,583,011 and made a total of 19 awards over eight categories to a value of £779,335. Success rate: 51%.

A list of the successful applicants can be found in the following table and abstracts can be viewed at: http://bit.ly/2x22mmk

AAGBI/Anaesthesia research grants

<table>
<thead>
<tr>
<th>Name</th>
<th>Institution</th>
<th>Title</th>
<th>Award Amount</th>
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</thead>
<tbody>
<tr>
<td>Dr Richard Armstrong</td>
<td>University College, London</td>
<td>Feasibility and safety of delivering a ketone drink to comatose survivors of out-of-hospital cardiac arrest</td>
<td>£32,643</td>
</tr>
<tr>
<td>Dr Thomas Craig</td>
<td>Portsmouth Hospitals NHS Trust</td>
<td>Critical appraisal of the nocturnal distribution of light exposure in intensive care (CANDLE)</td>
<td>£4,995</td>
</tr>
<tr>
<td>Dr Clare Melkan</td>
<td>Royal Free Hospital, London</td>
<td>Alterations in coagulation profile following orthotopic liver transplantation</td>
<td>£32,423</td>
</tr>
<tr>
<td>Professor Gary Mills</td>
<td>Royal Hallamshire Hospital, Sheffield</td>
<td>Assessment of ventilatory management during general anaesthesia for robotic surgery and its effects on postoperative pulmonary complications (AVAtaR): A prospective observational multicentre study</td>
<td>£14,589</td>
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Anaesthesia/Wiley research grant

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<th>Name</th>
<th>Institution</th>
<th>Title</th>
<th>Award Amount</th>
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<tbody>
<tr>
<td>Dr Michael Lee</td>
<td>University of Cambridge</td>
<td>Capturing the temporal course of reported pain and its relief from diagnostic facet joint blocks to inform the prediction of successful facet joint denervation (FAST-facet study)</td>
<td>£48,364</td>
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APAGBI small research grant

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<tr>
<th>Name</th>
<th>Institution</th>
<th>Title</th>
<th>Award Amount</th>
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</thead>
<tbody>
<tr>
<td>Dr Ramani Moonesinghe</td>
<td>University College Hospital, London</td>
<td>Children's acute surgical abdomen programme pilot (CASAPP)</td>
<td>£40,000</td>
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BJA/RCoA international collaborative grants

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<tr>
<th>Name</th>
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<th>Award Amount</th>
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<tbody>
<tr>
<td>Professor D Buggy</td>
<td>University College Dublin</td>
<td>Can perioperative anaesthetic-analgesic techniques during cancer surgery influence cancer outcome?</td>
<td>£99,992</td>
</tr>
<tr>
<td>Professor D Ma</td>
<td>Imperial College London</td>
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BJA/RCoA project grants

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<th>Name</th>
<th>Institution</th>
<th>Title</th>
<th>Award Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professor H Galley</td>
<td>University of Aberdeen</td>
<td>Investigation of the potential of negative regulation of nuclear factor kappa B using a novel antibody under conditions of sepsis</td>
<td>£30,179</td>
</tr>
<tr>
<td>Dr T Young</td>
<td>University of Aberdeen</td>
<td>Tracking the molecular and metabolic fingerprints of inhalational versus intravenous anaesthesia in breast cancer</td>
<td>£169,787</td>
</tr>
<tr>
<td>Dr Ishan Nagy</td>
<td>Imperial College London</td>
<td>Mapping inflammation-induced mitogen- and stress-activated protein kinase 1/2-dependent</td>
<td>£90,123</td>
</tr>
<tr>
<td>Dr Jon Silversides</td>
<td>Craigavon Area Hospital, Belfast</td>
<td>Determining the mechanisms by which active deersuscitation in stable critically ill patients may modulate clinical outcomes</td>
<td>£149,731</td>
</tr>
<tr>
<td>Dr Michael Wilson</td>
<td>Imperial College London</td>
<td>Investigation of the cyclophilin A-CD147 axis as a novel mediator of ventilator-induced lung injury</td>
<td>£169,847</td>
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DAS small research grants

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<tr>
<th>Name</th>
<th>Institution</th>
<th>Title</th>
<th>Award Amount</th>
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</thead>
<tbody>
<tr>
<td>Dr Maria Chereshneva</td>
<td>Guys and St Thomas' Hospital, London</td>
<td>New videolaryngoscopy scoring system development</td>
<td>£1,804</td>
</tr>
<tr>
<td>Dr Claire Gillan</td>
<td>St John's Hospital, Scotland</td>
<td>The use of a second-generation LMA as a rescue device in patients with previous head and neck radiotherapy</td>
<td>£12,000</td>
</tr>
<tr>
<td>Dr Mark Raper</td>
<td>Princess of Wales Hospital, Cardiff</td>
<td>Developing a framework for the assessment of single-use video laryngoscopes</td>
<td>£12,000</td>
</tr>
<tr>
<td>Dr Thungas Sethy</td>
<td>University College London Hospitals</td>
<td>Clinical trial of transnasal humidified rapid-insufflation ventilatory exchange (THRIVE) oxygen in women having planned caesarean delivery</td>
<td>£12,035</td>
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OAA large project grant

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<tr>
<th>Name</th>
<th>Institution</th>
<th>Title</th>
<th>Award Amount</th>
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</thead>
<tbody>
<tr>
<td>Dr David T Monks</td>
<td>St Thomas' Hospital, London</td>
<td>A comparison of intrathecal hyperbaric prilocaine versus bupivacaine for regional anaesthesia indicated for cervical cerclage in pregnancy: A randomised controlled trial (PRILOCC trial)</td>
<td>£53,383</td>
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VASGBI project grant

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<tr>
<th>Name</th>
<th>Institution</th>
<th>Title</th>
<th>Award Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Simon Hawell</td>
<td>University of Leeds</td>
<td>The role of preoperative assessment in effective vascular multidisciplinary team decision-making</td>
<td>£35,592</td>
</tr>
</tbody>
</table>
Letters to the Editor

If you would like to submit a letter to the editor please email bulletin@rcoa.ac.uk

One size doesn’t fit all

Sir,

Catheter mounts come in a standard size with 22mm male (22M) and 15mm female (15F) at the patient end. An anaesthesia facemask has a 22F connector which is compatible with all standard catheter mounts.

We’ve identified a potential patient safety risk with the Portex fiberoptic bronchoscope (FOB) swivel connector. It has a 15F patient end which fits the 15M end of an endotracheal tube (ETT) and a supraglottic airway device. However, it is not compatible with a conventional anaesthesia facemask because although the white end is the correct size (i.e. 22M/15F), it is only about 2mm deep. The overhanging blue encasement prevents the connector from being inserted into a conventional face mask [see arrow in image].

We don’t understand the purpose behind this design and why this product is manufactured thus. The equivalent alternative manufactured by Intersurgical has a 22M/15F connector which is compatible with a face mask and ETT. Both products are widely available.

In the event of an accidental dislodgement of ETT during FOB using the Portex connector, immediate bag-mask ventilation would be impossible. This is our principal concern. We wish to raise awareness of this incompatibility and welcome thoughts from colleagues about the purpose behind this design.

Dish Vishal Salota and Dr Suparna Das,
Consultant Anaesthetists, Queen Elizabeth Hospital, London

A response from Dr Neil McGuire,
Clinical Director of Devices,
Medicines and Healthcare products
Regulatory Agency (MHRA)

This device has been discussed with the manufacturer and the Instructions For Use (IFU) state:

‘......connector,........ with a right angle single axis 360° swivel to help eliminate the transmission of undesirable torque and motion between the patient’s breathing system and the tracheal or tracheostomy tube.’

‘If using the Fibre-Optic Bronchoscope connector it should be removed and replaced with a standard swivel connector following the Fibre-Optic Bronchoscope procedure.’

‘Disconnection may be facilitated with the use of a disconnection wedge’

‘15mm Reusable Swivel Connectors should not be used for the administration of continuous flow oxygen or other gases.’

It is clearly only for use with a tracheostomy or endotracheal tube during a bronchoscopy, where a mask would never be used and its function is to reduce torque while allowing continued ventilation with PEEP preservation. Therefore, it’s not compatible with a facemask and should be removed as soon the bronchoscopy is completed. It is a very secure fit to avoid disconnection, which makes release awkward, particularly in an emergency, often needing a wedge. If the tube was displaced you’d need a completely new breathing system with a mask or alternative, something you would normally be well prepared for when undertaking an airway procedure.

My story with the College... trust and empowerment

Sir,

I was graduating overseas when our College was granted a Royal Charter. It then took me nine years, two theses and a doctorate exam to qualify. Escorting my late father to the UK for treatment, I decided that this was where I’d eventually practice anaesthetics but dreaded having to restart from scratch with the Professional and Linguistic Assessments Board (PLAB). Eureka! I received an email from Mrs Sandra Wood accepting my application for a CCST (ODTS) application. Soon, I was a registered overseas doctor. I was graduating overseas when our College was granted a Royal Charter. It then took me nine years, two theses and a doctorate exam to qualify. Escorting my late father to the UK for treatment, I decided that this was where I’d eventually practice anaesthetics but dreaded having to restart from scratch with the Professional and Linguistic Assessments Board (PLAB). Eureka! I received an email from Mrs Sandra Wood accepting my application for a CCST (ODTS) application. 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TSP ONE YEAR IN

Mr Aaron Woods, RCoA Technology Strategy Programme Director

The Technology Strategy Programme (TSP) is a three-year change programme which will impact every aspect of College technology. One year in, the TSP Director reflects on the programme so far.

What’s been happening?
We are over halfway through the development of the Lifelong Learning Platform. The initial rollout will include e-Portfolio and Logbook functionality with CPD functionality being added later in 2018. This is one of the biggest projects in the TSP and will deliver an easily accessed, integrated platform to support you in your career-long learning. It will be quicker and simpler to log your learning as part of the working day, and when it comes to your Annual Review of Competence Progression (ARCP), all the information you need as a trainee or assessor will be in one place.

We have selected and begun implementing a new unified communications system, which will replace the current phone and virtual conferencing facilities. If you work directly with the College, the new system will provide a more stable and user-friendly experience of joining meetings by phone or video, saving you time on travel and supporting remote collaboration.

Successes
For me, the biggest success so far is not any one new project or system choice, but the way in which the membership voice is being heard loud and clear in regards to what they want from their technology. We have had excellent member engagement on the Lifelong Learning Platform project with hundreds of survey responses, and many members across the UK, taking part in face-to-face and virtual system design/testing sessions. The most important job of the TSP is to understand and deliver what the members need, and you have been brilliant in giving your time and thought to this.

Another success at this stage, I would say, is how we have looked at the big picture of designing/selecting systems which will work as an integrated whole. It is tempting to leap ahead and start to implement new systems as fast as possible so members get early benefit, but it is vitally important to take a step back and ensure the website will talk to the exams system, or the membership system will talk to the finance system, etc. The TSP has run an enterprise architecture design phase to achieve this and ensure all the pieces of the puzzle fit together.

Challenges
Time: A technology change programme is entirely reliant on the input of those the change is for the benefit of, and its demands can be high on people who already have an intense day (and night) job to do. Due to the eight-week lead time required for clinicians to book time out, and the very short notice they may get when required at work, it can make it very challenging to organise the time and logistics to get member input. What is not in doubt, however, is the willingness and personal time so many of you are prepared to give to get this right.

We have also selected and begun implementing a new unified communications system, which will replace the current phone and virtual conferencing facilities. If you work directly with the College, the new system will provide a more stable and user-friendly experience of joining meetings by phone or video, saving you time on travel and supporting remote collaboration.

Where to start? With such a large programme consisting of over 30 separate projects, working out the best place to start and the sequence in which to proceed is a daunting task. Something which may appear an obvious start point may actually have to wait due to a dependency on something else; something might appear urgent to fix but you may be contract timebound with a supplier and so on. I would describe getting this right as winning at a cross between Cluedo and Buckeroo – solving the mystery and not dropping anything in the process!

What comes next?
The project to introduce computer-based testing at regional centres starts this autumn. Autumn also sees us start the document collaboration project. This will introduce a new system to enable online document sharing and real-time collaboration – particularly useful if you are a committee member, or involved in research or exam question setting.

Our work to redesign the website and introduce a new member portal began in September, so by the time of reading we should be well into the process of mapping and documenting what we need from the new site. The first stage of an exciting 18-month project.

If you have any questions or would like more information please get in touch via tsp@rcoa.ac.uk.
AS WE WERE...

Dr David Zuck (4 June 1923 to 2 November 2016)

An appreciation

Dr David Zuck, founding author of this column, died aged 93, just one year ago. I first met David in 1996, when we organised a series of historical exhibitions at the AAGBI. When I say ‘we organised’ I mean that I was the honorary curator of the Charles King Collection, and so technically responsible. David told me what was needed and where to find it. I did as I was told, and the exhibitions were a great success.

It was apparent that he was a man of tremendous learning, a genuine scholar and a font of wit and wisdom. He was gentle, but with a knack for puncturing pomposity, especially ignorant pomposity.

In 2002, when I was editor of the College Bulletin, I invited him to write an occasional historical column, entitled ‘As we were’. The first column appeared in September 2002, there was a column in every issue of the Bulletin after that. Indeed, there have been columns from beyond the grave, with the last appearing in March 2017, because the completed articles were already in the pipeline.

He was an editor’s dream. Every article arrived, word perfect, on or before time. He was an editor’s dream. Every article was told, and the exhibitions were a great success.

Always a voracious reader, when in 1988, he retired from his post as consultant anaesthetist at Enfield District Hospitals, he had more time to indulge his varied interests. These were reflected in the ‘As we were’ columns. The first started ‘As the law stands at present, the administration of anaesthetics is under no regulation’, quoting from a Coroner’s Committee report of 1910.1 David then went on to make an acerbic comment on the current state of the law in 2002, quoting Archbold.

The last column is about Chevalier Jackson’s careful foray into bronchoscopy, to extract foreign bodies from the tracheas of small children.2 In between, the subjects include spinal anaesthesia, brain death, the horrors of transfusiology in children before the widespread use of anaesthesia (described by the surgeon as ‘not required’), motorising tips, ‘sexual passion in patients under the influence of ether’, controversies in monitoring, the ‘As we were’ column in the Bulletin.

He loved new technology, being, rather surprisingly, a bit of a geek. He often sent emails late at night. I never knew what to expect – either a piece of profound scholarship or a brilliant, not always respectable, joke. Both were equally welcome.

When I wanted to know something of anaesthetic interest, he was my first point of reference – faster than Google and more accurate than Wikipedia.

We have lost a great teacher, in the best and widest sense of the word.

References
1 As We Were, RCoA, Bulletin 2002; 15:753
2 As We Were, RCoA, Bulletin 2003; 17:852
3 As We Were, RCoA, Bulletin 2017; 102:62–63
4 As We Were, RCoA, Bulletin 2003; 21:1058

For more information on the Lives of the Fellows project please visit:
www.rcoa.ac.uk/lives-of-the-fellows
REPORT OF A MEETING OF COUNCIL

At a meeting of Council held on Wednesday 20 September 2017, Dr Liam Brennan was admitted as President for the year 2017–2018. Professor Ravi Mahajan and Dr Janice Fazackerley were admitted as Vice-Presidents for the year 2017–2018 and Dr Jeremy Langton was presented with a Past Vice-President’s Medal.

College Tutors
Northern Ireland
* Dr G V Browne (Craigavon Area Hospital)

Scotland
South East Scotland
Dr S D J Bolton (NHS Rfle) in succession to Dr A Raganowski

West of Scotland
Dr S E Mollveney (Royal Hospital for Children) in succession to Dr R Faigrieve

England
East Midlands North
* Dr J Davies (Nottingham City Hospitals) in succession to Dr M Way

Kent, Surrey & Sussex
Dr M I Berry (Royal Surrey County Hospital) in succession to Dr M Blackmore

Dr Mark Alfird (Cambridge), Dr Gail Browne (Northern Ireland) and Dr Ayodele Obideyi (Great Yarmouth) were all admitted to the Fellowship ad eundem.

The following appointments/re-appointments were approved (re-appointments marked with an asterisk):

*Dr J Davies (Nottingham City Hospital) in succession to Dr R Faigrieve

Dr M I Berry (Royal Surrey County Hospital) in succession to Dr M Way

Dr S E McIlveney (Royal Hospital for Children) in succession to Dr K M Zander

East Midlands
East Midlands North
Dr Oliver Griffith
Dr Anagha Tambe

East Midlands South
Dr David Marriott

East of England
Dr Siddhartha King
Dr Drew Walsh (PHEM)

Kent, Surrey & Sussex
Dr Tara Nejim

London
Imperial
Dr J Campbell (Queen Charlotte’s Hospital & Hammersmith Hospital) in succession to Dr L Hamlyn
Dr P Annamala (Hammersmith Hospital) in succession to Dr S P Kemp

North West
Dr Andrew Bailey
Dr Maria Chazopis
Dr Ben Clevenger
Dr Simon Goodard
Dr Benjamin Persans
Dr Joanna Simpson
Dr Serena Sodha
Dr Amy Stead

Barts & The London
Dr Martha Campbell
Dr Gurpreet Gill
Dr Geetha Gunaratnam
Dr Peter Keogh
Dr Rebecca Martin
Dr Radha Sabaratnam
Dr Daniel Sellers
Dr Thomas Tarrell

Certificate of Completion of Training
To note recommendations made to the GMC for approval, that CCTs/CESR (CP)s 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.

South East
Dr Aidan Devlin
Dr Benjamin Rudge
Dr Catalina Stendall

St George’s
Dr Zain Malik
Dr Elizabeth O’Donohoe
Dr Holly Sturgess
Dr Sarah Wilkinson

North West
Dr Graham McNamara
Dr Andrew McTavish
Dr Alison Quinn
Dr Fiona Wallace Dual (ICM)
Dr Wei Teo

Northern
Dr Amitabh Aggarwal
Dr Ashish Bartakke
Dr Claire Biercamp
Dr Maciej Bajowcz
Dr Mark Collaghan
Dr Helen Chipchase
Dr Mohamed Eid
Dr Adrian Gooding
Dr Vaughan Jones
Dr Savio Law
Dr Andrew McDonald
Dr Edward Pugh
Dr Adnaan Qureshi
Dr Catharine Rimmer
Dr Nicholas Sheppard

North Eastern
Dr Anna Laird
Dr Neil McLoughlin

North Western
Dr Andrew McTavish
Dr Graham McNamara

Yorkshire
Dr Suneet Nayee
Dr Myra Malik

South Yorkshire
Dr Andrew McDonald
Dr Edward Pugh
Dr Adnaan Qureshi
Dr Catharine Rimmer
Dr Nicholas Sheppard

North Western
Dr Anna Laird
Dr Neil McLoughlin

Manchester
Dr David Freeman
Dr Arul Garg (ICM)

Stoke
Dr V Shru Machineni

Warwickshire
Dr Sudheen Jillela

Yorkshire & The Humber
East & North Yorkshire
Dr Ashley Bartakke
Dr Claire Biercamp
Dr Maciej Bajowcz
Dr Mark Collaghan
Dr Helen Chipchase
Dr Mohamed Eid
Dr Adrian Gooding
Dr Vaughan Jones
Dr Savio Law
Dr Andrew McDonald
Dr Edward Pugh
Dr Adnaan Qureshi
Dr Catharine Rimmer
Dr Nicholas Sheppard

Northern Ireland
Dr Anna Laird
Dr Neil McLoughlin

West Yorkshire
Dr Martyn Robertson

East Scotland
Dr Jennifer Bain Joint (ICM)
Dr David Falcon
Dr Caroline Ferguson Joint (ICM)
Dr Seweun Garioc
Dr Simon Heaney
Dr Jennifer Service

West of Scotland
Dr Cara Marshall

South West
Severn
Dr Ian Davies
Dr Toby Jacobs
Dr Neil Kellie
Dr Tom Knight

Wales
Dr Lewys Richmond

Wessex
Dr Kian Patel

South West
Severn
Dr Ian Davies
Dr Toby Jacobs
Dr Neil Kellie
Dr Tom Knight

Wales
Dr Lewys Richmond

Wessex
Dr Kian Patel

South West
Severn
Dr Ian Davies
Dr Toby Jacobs
Dr Neil Kellie
Dr Tom Knight

Wales
Dr Lewys Richmond

Birmingham
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Stoke
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Dr Helen Chipchase
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Dr Martyn Robertson

East Scotland
Dr Jennifer Bain Joint (ICM)
Dr David Falcon
Dr Caroline Ferguson Joint (ICM)
Dr Seweun Garioc
Dr Simon Heaney
Dr Jennifer Service

West of Scotland
Dr Cara Marshall
GUIDELINES FOR THE PROVISION OF ANAESTHESIA SERVICES (GPAS)

GPAS forms the basis of recommendations produced by the Royal College of Anaesthetists (RCoA) for healthcare managers and anaesthetists with responsibilities for service delivery.

Chapters are developed using a rigorous, evidence-based process, accredited by the National Institute for Health and Care Excellence (NICE). By the publication of GPAS 2019, it is anticipated that all chapters in GPAS will have been developed using the new process.

How do I get involved?
The RCoA is currently recruiting Chapter Development Group members for the following chapters:

- head and neck surgery
- vascular surgery
- pain management.

Chapter Development Group (CDG) members support the authors to develop the GPAS chapter by commenting on drafts. CDG members include subject-matter experts, Clinical Directors, at least one lay member to represent the interests of patients, anaesthetists of all grades and College staff.

If you are interested in getting involved, please contact the GPAS Co-ordinator via email gpas@rcoa.ac.uk or telephone: 020 7092 1572.

DEATHS

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

Dr Dorothy Bardgett
Cheshire

Dr Noel Cass
Victoria, Australia

Dr Moira Hainsworth
Bangor

Dr John Hicks
Lancashire

Dr Donald Moir
Perthshire

Dr John McKenna
Scotland

Dr Gordon Ostlere
Bromley

Professor Dame Margaret Turner-Warwick
Exeter

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 RCoA website (www.rcoa.ac.uk/obituaries).

APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

The College congratulates the following Fellows on their consultant appointments:

Dr Alexandra Day, York Hospital

Dr Aidan Devlin, King’s College Hospital

Dr Anand Damodaran, Heart of England NHS Foundation Trust

Dr Edward Dyson, Kettering General Hospital

Dr Naomi Hyndman, Royal Infirmary Edinburgh

Dr Zain Malik, Ashford and St Peter’s Foundation Trust

Dr Angus Mcknight, Oxford University Hospitals

Dr Siream Nashri, Milton Keynes Hospital

Dr Sunet Navee, Imperial College NHS Trust

Dr Desire Onwochei, Guy’s and St Thomas’s Hospital, London

Dr Michael Shaw, Guys and St Thomas’ Hospitals, London

Dr Anthony Wilson, Central Manchester University Hospitals NHS Foundation Trust

APPOINTMENT OF MEMBERS, ASSOCIATE MEMBERS AND ASSOCIATE FELLOWS

Associate Member

Dr Anita Jonas

Affiliate – Physicians’ Assistant (Anaesthesia)

Dr Ella Davies
The Writers Club has seen more than 750+ trainees through the SAQ Papers with a successful Pass Rate for those who have kept to the necessary disciplines. But many trainees apply far too close to the examination to derive anything like the full benefit from Membership. That Full Benefit includes Free Admission to the SAQ Weekend Courses, the Acquisition of a large and useful Collection of Answer Sheets and a Valuable Motivation towards Sustained Revision.

Membership Fee: A Single Payment of £400

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

Attendance to the SAQ Weekend Courses – Free of Charge

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

Candidates are urged to Join before March 2018 for the Autumn 2018 Examination to reap Maximum Benefit

Enquiries to: writersclub.msa@gmail.com

Courses for the Royal College of Anaesthetists Examinations

<table>
<thead>
<tr>
<th>Courses</th>
<th>Dates 2017/18</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary SBA/MCQ</td>
<td>26 January–1 February</td>
<td>July 2018</td>
</tr>
<tr>
<td>Primary OSCE Weekend</td>
<td>15–17 December</td>
<td>April 2018</td>
</tr>
<tr>
<td>Primary Viva Weekend</td>
<td>5–7 January</td>
<td>April 2018</td>
</tr>
<tr>
<td>Primary OSCE/Orals</td>
<td>12–19 January</td>
<td>May 2018</td>
</tr>
<tr>
<td>Final Written ‘Booker’</td>
<td>4–8 February</td>
<td>August 2018</td>
</tr>
<tr>
<td>Final SAQ Weekend</td>
<td>9–11 February</td>
<td>August 2018</td>
</tr>
<tr>
<td>Final SBA/MCQ</td>
<td>12–18 February</td>
<td>August 2018</td>
</tr>
<tr>
<td>Final Viva Revision</td>
<td>4–9 November</td>
<td>May 2018</td>
</tr>
<tr>
<td>Final Viva Weekend</td>
<td>24–26 November</td>
<td>June 2018</td>
</tr>
</tbody>
</table>

‘I am now processing the fact that I passed. I am a little sad that this is the end of me attending Mersey courses. It is rare in life that we meet someone so dedicated to helping us succeed. Working for these exams can be demoralising and miserable, and I owe my success (in part) to the hard work and dedication of DG, Kirstie, Faculties et al at the MSA Courses’

– Final Viva Candidate, June 2017

‘Thank you again for all your hard work, encouragement and keeping us all in line. I sat the Primary written 3 times before eventually finding Mersey and haven’t had to do a resit since! Thank you so much!’

– Final Viva Candidate, June 2017

‘Firstly massive thanks to all of the Team at the MSA. I think that is 6 of your courses that I have attended and I am very pleased to say I passed my final viva last week!

With regards to Dr Gray’s many recommendations, points of advice, instructions, and demands, I should probably include a response...

He is right. About all of it’

– Final Viva Candidate, June 2017

To see details of all of our courses please visit: www.msoa.org.uk

or contact us at: enquiries@msoa.org.uk

‘Like’ Mersey School of Anaesthesia on Facebook for News and Updates
AIRWAY WORKSHOPS

Don’t forget to vote in the Council election. Ballots were distributed on Friday 20 October and the election closes on Monday 4 December.

Those eligible to vote are:
- fellows (apart from Honorary Fellows) for the five consultant Council vacancies
- all anaesthetic trainees registered with the College for the one trainee Council vacancy.

If your membership fits one of these categories and you haven’t received a ballot email from RCoAvote@electoralreform.co.uk, please contact ceo@rcoa.ac.uk and include your College Reference Number (CRN).

ELECTION TO COUNCIL 2018

Please vote by 4 December 2017

Our airway events provide an opportunity to learn core airway management techniques from experienced consultants. There is hands-on practical experience with commonplace airway equipment as well as plenty of discussion on airway management including current UK guidelines. Appropriate for all grades of anaesthetic trainees, specialty doctors and consultants.

Airway Workshops
- 7 February 2018
  RCoA, London
- 18 April 2018
  RCoA, London

Tracheostomy Masterclass
- 9 March 2018
  RCoA, London

Airway Management: Training the Trainer
- 10 May 2018
  RCoA, London

Airway Leads Day
- 15 March 2018
  RCoA, London

Agenda, Abstract Submission, Faculty and Full Details: www.ebpom.org

*Delegates must be RCoA registered trainees/Senior Fellows to be eligible for this rate.
**EVIDENCE BASE IN CURRENT ANAESTHETIC PRACTICE**
30 November 2017 | RCoA, London

Gain insight into current research whilst also looking at how this research ensures the continuation of safe practice. Sessions include:
- patient reported outcome measures
- achievements of postoperative lower limb analgesia
- can cardiopulmonary exercise testing, in high-risk patients undergoing high-risk surgery, improve outcomes?

**PAEDIATRIC ANAESTHESIA**
1 February 2018 | RCoA, London

With a focus on paediatric anaesthesia the day will cover a range of topics from the challenges facing current anaesthetists and how best to deal with trauma cases. Sessions include:
- anaesthetic management of uncooperative and difficult children
- total intravenous anaesthesia for tots
- the intensive care management of Manchester bombing victims.

**PERIOPERATIVE MEDICINE**
28 February 2018 | RCoA, London

Learn the latest about the integrated medical care of patients from the moment of contemplation of surgery until full recovery. Sessions include:
- role of anaesthetist as a perioperative physician
- criteria for admission to HDU and ITU
- best practice for an enhanced recovery programme.

**REGIONAL ANAESTHESIA**
19 March 2018 | RCoA, London

Find out the latest techniques in regional anaesthesia gaining knowledge of this specialist technique to reduce unwanted complications. Sessions include:
- peripheral nerve catheters and continuous wound infusions
- ultrasound and neuroaxial blocks
- the role of regional anaesthesia in paediatric practice?

**Other upcoming CPD Study Days**

**CPD Study Day**
- 17 November 2017 | Royal Hotel, Hull
- 18 November 2017 | RCoA, London

**Managing Mass Casualties**
- 18 April 2018 | RCoA, London

**CPD Study Days**
- 12–13 June 2018 | RCoA, London

*A delegates must be RCoA registered trainees/Senior Fellows to be eligible for this rate.

---

**PATIENT SAFETY EVENTS**

A series of events highlighting safety issues falling within the anaesthesia care pathway. These events will help to establish and maintain good anaesthetic practice and high quality service in the evolving UK healthcare environment.

**SALG Patient Safety Conference**
22 November 2017 | Manchester Conference Centre

**Quality Improvement (Oi) and Patient Safety**
21 March 2018 | RCoA, London

**Safe Anaesthesia Seminar 2018**
20 April 2018 | RCoA, London

**TRAUMA CARE IN CONFLICT: CIVILIAN AND MILITARY PERSPECTIVES**

12 December 2017 | RCoA, London

This event is in collaboration with the Tri-Service Anaesthetic Society

A unique opportunity to hear from expert anaesthetists who have responded to trauma in war zones and the aftermath of terrorist attacks in the UK. Sessions include:
- innovation in conflict
- delivering critical care in non-permissive environments
- responding to disasters
- learning from recent conflicts

**UPDATES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT**

Discover topics on the anaesthetic horizon and how they will influence your practice now and in the future. Sessions include:
- perioperative medicine
- patient safety and quality improvement
- cardiology, intensive care, obstetrics, paediatrics, regional anaesthesia and emergency medicine

**EXAM REVISION COURSES**

Our revision courses are designed to aid trainees in their studies in the run up to the Primary and Final FRCA exams. They use a mixture of lectures, practice multiple choice questions (MCQs) and single best answer (SBA) examinations.

**Primary FRCA Masterclass**

**Final FRCA Revision Course**

*Delegates must be RCoA registered trainees/Senior Fellows to be eligible for this rate.

---

**CPD STUDY DAYS**
#RCoAcpd

Our CPD Study Days are designed for busy doctors, to efficiently maintain competence and aid with revalidation in anaesthetic and surgical practice. These study days 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 better cope with the demands of everyday working life.

**68 | Book your place at www.rcoa.ac.uk/events**

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**68 | Book your place at www.rcoa.ac.uk/events**
Our GASAgain courses provide strategies for managing a return to work. Not only are there simulation scenarios to refresh your skills, but we also provide a series of workshops underpinned by short lectures to update you on the latest in the world of anaesthesia.

Bradford Royal Infirmary
21 February 2017
RCoA, London
20 April 2018
Royal Bournemouth Hospital
13 June 2018

Fees

<table>
<thead>
<tr>
<th>Standard</th>
<th>Trainee*</th>
<th>Senior Fellow*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop</td>
<td>£240</td>
<td>£180</td>
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<tr>
<td>Symposium</td>
<td>£200</td>
<td>£150</td>
</tr>
<tr>
<td>Book both workshop and symposium and save £100 (£70 for Trainee)</td>
<td>£340</td>
<td>£260</td>
</tr>
</tbody>
</table>

What you can expect
- Stay informed with lectures on global safety, perioperative medicine and the NHS in 2018.
- Get up-to-date via quick-fire talks on obstetric haemorrhage, paediatric airway, acute pain and head injuries.
- Tailor your day with practical workshops on topics including stress, shared decision making and management.
- Have your say during audience interaction and controversial debate.

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

Visit www.rcoa.ac.uk/events and select the event you wish to attend.
Click BOOK NOW and follow the step-by-step process. Receive an instant email receipt and confirmation of your booking.

*Delegates must be RCoA registered trainees/Senior Fellows to be eligible for this rate.
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EASE OF USE. EASY TO LEARN.

INTUITIVE NAVIGATION: 15" Screen with quick touch controls.

UNIFIED USER INTERFACE: Unified CARESCAPE user interface between ventilator and patient monitors.

APL AND SWITCH: Primary controls comfortably within reach.

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BREATHING CIRCUIT CASSETTE: Breathing circuit can be quickly dismantled without tools.

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PAUSE GAS FLOW: A workflow solution that simplifies temporary circuit disconnects.

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CPD Accredited Education Modules:

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For more information, please contact:
gehealthcare.learningcentre@ge.com
ICS State of the Art: too good to leave to the intensivists
Dec 4-6th, ACC Liverpool. soa.ics.ac.uk

Star speakers. Innovative format. Clinical relevance. Welcoming environment. Social & networking focus. Isn’t it time you made the leap?

International speakers include:

Peter Bradley
Michel Ghezzi
Elisabeth de Waziers
Robedjoe Gele
Terri Hough
Michelle Kio
Feoper Tihut
Gordon Rubenstein
Pascal Franckx
Paul Young
Paul Zaidi

UK speakers include:

Kay Blashford
Bromley
Bent
Catherine
Gareth Davies
Sophie Forrester
Pascale Grider
Julie Higman
Mark Lee-Kim
Andy Johnson
Caroline Leach
Ewan Purcell
Tom Walsh

Monday 04 December 2017
Pre-plenary warm-up
Soapbox talks in critical care (pop-up stage)

Opening plenary:
Managing victims of terrorism: a clinical guide
Early mobilisation: It looks good, but are we treating them or treating us?
Big units, small units, one-size-fits-all national standards: do we all need to be the same?

Main sessions:
End of life: a global round table
Peri-operative critical care: a waste of time?
Robotics in healthcare
New technology and nutrition
Cutting-edge acute medicine: PE, acute pancreatitis, and clot retrieval
Critical care echo in 2017
New frontiers in infection management
Early mobilisation: pragmatic advice
How we do it: website and podcast skills
Women in critical care: a call to arms

Drinks reception
Concurrent informal sessions
Trainees Pecha Kucha session

Facilities throughout SOA17:
high-speed wifi, parent & child room, coffee & lunch, members’ lounge, quiet room.

Tuesday 05 December 2017
Breakfast sessions:
Clinical reviews of the year

Main sessions:
Trauma resuscitation and prehospital science
‘How I manage…’ – real-life scenarios
Interprofessional education & simulation

Trial design workshop
Major incidents: current threats & planning
Terrorist incident round table: clinical voices from Nice, London, Manchester
Busting myths in critical care
Mechanical ventilation & weaning
Lights, sound, action: noise & the ICU environment
Trauma specialties: burns, bones, neuro
Trauma outcomes: waking up in a different body
Endocrine & metabolic issues in critical care
ARDS: what have we learned since Berlin?
Wellbeing and burnout: next steps
Sepsis: new perspectives
Renal masterclass
Tracheostomy & managing the altered airway
David Bennett session: Paul Young

2nd drinks reception (free) & late party with live band (£20/head)

Wednesday 06 December 2017
Breakfast sessions:
Clinical reviews of the year

Main sessions:
Acute heart innovations and interventions
Bad drugs: street drugs, anaphylaxis, novel agents
Peri-operative medicine 2: SNAP-2, FLO-ELA & preventing post-op complications
Implementation science: paper to patient
Non-cardiac ultrasound masterclass
The Cauldron
Cancer critical care
Difficult airways in ICU: guidelines & controversy
Building the perfect ICU
Research clinic
Closing plenary
UK research
The big trials: hot off the press
Ongoing research
Translating to clinical practice

Visit our website for details of programme, speakers, registration, abstract submission, travel & accommodation
soa.ics.ac.uk

15 CPD points (RCoA pending)
Abstract Deadline: 04 Sep 17
Early Bird Deadline: 17 Oct 17

Full meeting (day rate available on https://soa.ics.ac.uk)
Early Bird Until 17 Sept Standard After 17 Sept
Consultant £450/£575 £495/£625
Trainee/SAS/ Med Student £390/£520 £445/£565
Nurse/AHP/ Med Student £190/£255 £225/£280

Prices shown for *ICG members / non-members. Join ICG via the registration page.

INTENSIVE CARE SOCIETY
ACC LIVERPOOL DEC 4-6™

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