Evidence to drive improvement

Supporting clinical innovation in anaesthesia

The US prescribed-opioid epidemic: lessons for perioperative medicine in the UK

Patient information resources
EVENTS CALENDAR

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

www.rcoa.ac.uk/events

@RCoAnews

MARCH

After the Final FRCA – Making the Most of Training Years 5 to 7
13 March 2018
RCoA, London
£150

Airway Leads Day
Joint RCoA and Difficult Airway Society event
15 March 2018
RCoA, London
£150

CPD Study Day
16 March 2018
The Studio, Birmingham
£200 (£150 for trainees)*

Leadership and Management:
Leading and Managing Change
(Success with Service Development)
16 March 2018
RCoA, London
£220 (£165 for trainees)*

A Practical Introduction to Quality Improvement
21 March 2018
RCoA, London
£150 (£115 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)*

Research Methodology Workshop
Joint RCoA, BJA and NIAA event
19 April 2018
RCoA, London
£150 (£115 for trainees)*

GASAgain (Giving Anaesthesia Safely Again)
20 April 2018
RCoA, London
£240 (£180 for trainees)*

Delivering Anaesthesia Safely
20 April 2018
RCoA, London
£200 (£150 for trainees)*

SAS Conference: Career Progression
Joint RCoA and Academy of Medical Royal Colleges event
23 April 2018
RCoA, London
£150

MAY

Ethics and Law
9 May 2018
RCoA, London
£200 (£150 for trainees)*

Airway Management: Training the Trainer
10 May 2018
RCoA, London
£240 (£180 for trainees)*

UK Training in Emergency Airway Management (TEAM)
26–27 April 2018
Wrexham Maelor Hospital
£450

Developing World Anaesthesia
30 April 2018
RCoA, London
£200

UK Training in Emergency Airway Management (TEAM)
10–11 May 2018
Royal United Hospital Bath
£450

NIAA Annual Scientific Meeting
21 May 2018
RCoA, London
£45 (£35 for trainees)*

JUNE

Updates in Anaesthesia, Critical Care and Pain Management
4–6 June 2018
Royal College of Surgeons, Edinburgh
£490 (£370 for trainees)

Cardiac Disease
June 2018
See website for details
£395 (£295 for trainees)

Anaesthetists as Educators: An Introduction
5 June 2018
RCoA, London
£220 (£165 for trainees)*

UK Training in Emergency Airway Management (TEAM)
11–12 June 2018
Solihull Hospital
£450

CPD Study Day
12–13 June 2018
RCoA, London
Both days: £335 (£270 for trainees)*
One day: £230 (£175 for trainees)*

Airway Workshop
13 June 2018
RCoA, London
£240 (£180 for trainees)

GASAgain (Giving Anaesthesia Safely Again)
13 June 2018
Royal Bournemouth Hospital
£240 (£180 for trainees)*

FICM Annual Meeting: Mind the Gap
24 May 2018
RCoA, London
£180 (£90 for trainees and nurses)*

Introduction to Leadership and Management: The Essentials
30–31 May 2018
RCoA, London
£955 (£630 for trainees)*

*Delegates must be trainee or senior fellow members of the RCoA to be eligible for the reduced rate.

*Delegates must be trainee or senior fellow members of the RCoA to be eligible for the reduced rate.

#RCoAUpdates
#RCoACardiac

See website for details

Patients with heart disease can present on any elective list, and also as emergencies. The aim of this two-day event is to explore areas of clinical importance for all practising anaesthetists. Hear from presentations from expert cardiologists, anaesthetists, and intensivists, who bring a truly multidisciplinary approach to complex problems and make it easier to better understand the pathophysiology of heart disease and how to manage patients with often complex problems.

Cardiac Disease
June 2018
See website for details

Patients with heart disease can present on any elective list, and also as emergencies. The aim of this two-day event is to explore areas of clinical importance for all practising anaesthetists. Hear from presentations from expert cardiologists, anaesthetists, and intensivists, who bring a truly multidisciplinary approach to complex problems and make it easier to better understand the pathophysiology of heart disease and how to manage patients with often complex problems.

See website for details

Our three-day Updates events are intended for doctors engaged in clinical anaesthesia, pain management and intensive care medicine (ie consultants, trainees, staff and associate specialist grades or their overseas equivalent) who would benefit from a refresher of the latest updates in areas of practice they may be exposed to regularly or only occasionally. Experts will present up-to-date information on a wide range of topics, informing you of updates in basic sciences relevant to anaesthesia and allied specialties.

Cardiac Disease
June 2018
See website for details

£490 £370 £245
£195 £150 £100

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

www.rcoa.ac.uk/events

@RCoAnews

Book your place at www.rcoa.ac.uk/events
A new integrated and evidence-based model of care for patients project
prehabilitation and wellbeing

PREP-WELL: community
prehabilitation and wellbeing project
A new integrated and evidence-based model of care for patients prior to surgery

The President’s View
4
News in brief
8
Guest Editorial
12
Guidelines for the Provision of Anaesthetic Services (GPAS)
15
Anaesthesia Clinical Services Accreditation (ACSA)
16
Faculty of Intensive Care Medicine (FICM)
18
Faculty of Pain Medicine (FPM)
19
Patient perspective
20
Society for Education in Anaesthesia (UK)
22
SAS and Specialty Doctors
24
National Emergency Laparotomy Audit (NELA)
26
Perioperative Quality Improvement Programme (POQIP)
28
Clinical Directors’ National Executive Committee
30
Revalidation for anaesthetists
31
Making sense of perioperative medicine training
32
The very slow march to a paperless NHS
34
The Cappuccini test
36
New membership service to attract the next generation of anaesthetists
38
Improving trainee choices in anaesthetic recruitment
40
Ariana Grande: a name Manchester will never forget
42
RCoA patient information resources
48
Reforming College Governance
51
Election to Council 2018: meet the new members
52
Perioperative Journal Watch
54
Letters to the Editor
55
New to the College
57
As we were [or should be!]
61
Notices and adverts
63
College events
69

Evidence to drive improvement
How your College is working at the forefront of anaesthetic research

Page 4

Supporting clinical innovation in anaesthesia
The College has recently pledged its support and sponsorship for the NHS Clinical Entrepreneur programme

Page 44

The US prescribed-opioid epidemic: lessons for perioperative medicine in the UK
The second of two articles highlighting the US prescribed-opioid epidemic and the implications for UK anaesthetists

Page 46

RCoA patient information resources
Helping you meet the challenges of informing patients

Page 48

From the editor

Professor Monty Mythen
While financial and workforce pressures continue to be felt by anaesthetists across the NHS, three things remain constant – the support your College provides you, the need for change and the need for us all to ensure patient safety remains our utmost priority.

The College has undertaken a concerted effort over the past 12 months to engage with members to understand the pressures faced by anaesthetists of all grades. The 2016 – 2017 morale and welfare survey (http://bit.ly/2017-rcoasurvey) kick-started a year’s worth of face-to-face Listening Events with anaesthetists in training across the United Kingdom to better understand the pressures they face. Combined with information gathered at the Listening Events and the findings of the above-mentioned survey, the College released in December 2017 A report on the welfare, morale and experiences of anaesthetists in training: the need to listen (http://bit.ly/wmoraleexperiences). In this report we stated that cultural changes are needed across the NHS to effectively address issues of poor welfare and morale among doctors in training for all specialties.

The College has not stopped its work there – in November 2017, a Listening Event was held specifically for SAS doctors and themes identified during the discussion can be found on page 24. The College has also worked with the Association of Anaesthetists of Great Britain and Ireland (AAAGBI) and the Faculty of Intensive Care Medicine to launch a nation-wide multi-stakeholder initiative (http://bit.ly/2O70Y9Y) to address the impact of fatigue amongst doctors of all specialties. The final activity to note in relation to support provided by your is the winter pressure guidance (http://bit.ly/PROPAR) developed in partnership with the AAAGBI which the issue of anaesthetists being asked to work outside their normal scope of practice.

In this issue of the Bulletin, one important piece I encourage you to read is the link to the Safe Anaesthesia Liaison Group’s (SALG) Patient Safety Update – this can be found in the News in brief section on page 8. The SALG Patient Safety Updates contain anonymised incidents reported to the National Reporting and Learning System which are important learning opportunities for anaesthetists of all grades.

Quality improvement and innovation come hand-in-hand with both topics being addressed in this issue. Dr Liam Brennan discusses in his President’s View (page 4) how the College is working at the forefront of anaesthetic research. By hosting work of the internationally-renowned National Audit Projects, Sprint National Anaesthesia Projects, the National Institute of Academic Anaesthesia, the Health Services Research Centre and the UK Perioperative Medicine Clinical Trials Network to name a few, your College takes very seriously its role in collaborative audit and research. It’s a fascinating read.

Dr Anu Sahni and Professor Ramani Moonesinghe provide us with an update on the work of the Perioperative Quality Improvement Programme initiative (page 28) to reduce postoperative complications.

Speaking of the need for change, this will be my last issue as editor of the Bulletin. While I’ve thoroughly enjoyed the past two years of working with the Editorial Board and the communications team to rejuvenate this important publication, the time has come for fresh thinking and a new tack of editorial ideas.

I am very pleased that Council member Dr David Bogod will be taking over editorial duties from the May issue. No better person for the job.

A final thank you to the communications team and Editorial Board.

Dr David Bogod will be taking over from the editor of the Bulletin. While I’ve thoroughly enjoyed the past two years of working with the Editorial Board and the communications team to rejuvenate this important publication, the time has come for fresh thinking and a new tack of editorial ideas.

I am very pleased that Council member Dr David Bogod will be taking over editorial duties from the May issue. No better person for the job.

A final thank you to the communications team and Editorial Board.
As I sit down to write in January 2018 a winter storm is buffeting both Churchill House and the NHS in general, but with spring just around the corner I would like to take this opportunity to focus on sunnier horizons and discuss the College’s current and future work in the areas of research and quality improvement.

You will hopefully have noticed in recent editions of the Bulletin an increased number of articles relating to the College’s research outputs. As well as our well-established work streams such as the National Audit Projects (NAPs), we are also delivering an NHS England-commissioned national audit, several shorter-term projects, and our own national quality improvement programme. We have made renewed efforts to highlight these initiatives to our members – collaborative audit, quality improvement and research have always been a cornerstone of anaesthesia, and your own contributions to these initiatives are invaluable.

Ten years of the NIAA
The College is proud to be one of the four founding partners – along with the AAGBI, the BJA and Anaesthesia – of the National Institute of Academic Anaesthesia (NIAA) (www.niaa.org.uk), which this year celebrates its tenth anniversary. I know from speaking to colleagues that the NIAA model of research cooperation and co-production between stakeholder organisations is the envy of other specialties. Since its inception in 2008 the NIAA has distributed over £8.8 million in research funding via its biannual grant rounds.

As this edition of the Bulletin reaches your mailboxes, recruitment for a new chair of the NIAA will be underway. I would like to thank the outgoing chair, Professor Monty Mythen, for his hard work during his period of office in promoting the development of academic anaesthesia. I look forward to working with the new NIAA chair when they are appointed. Congratulations also to all current and previous members of the NIAA Board and Research Council, and the local researchers working on NIAA-funded projects, for laying the foundations the NIAA has built on over the last decade.

POMCTN, HSRC and ongoing projects
The NIAA has also overseen the establishment of both the Health Services Research Centre (HSRC) and
Since its inception in 2008 the NIAA has distributed over £8.8 million in research funding via its biannual grant rounds.
Simulation Leads Day

The College held a successful and engaging Simulation Leads Day at the Glasgow Caledonian University on 9 January. Hosted by the RCoA’s simulation working group chair Professor Bryn Baxendale, simulation leads from across Scotland attended to network, debate and share their experiences of simulation in training.

Engaging speakers showcased the range of simulation programmes taking place across Scotland. Dr Purva Makani, president of the Association for Simulated Practice in Healthcare, delivered a valuable session on simulation-based practice and the development of national standards.

College lay committee members Mr Les Scott and Mr Bob Evans were also in attendance and shared views on public and patient perspectives regarding simulation, in particular how simulation can be used for communication skills. The day stimulated rich conversation about the benefits and challenges of simulation, which will help the College formulate its simulation strategy later on this year.

Clinical Quality in 2018

The College’s clinical quality team is working towards the 2018 publication of the Guidelines for the Provision of Anaesthetic Services (GPAS) (www.rcoa.ac.uk/gpas) and the Anaesthesia Clinical Services Accreditation (www.rcoa.ac.uk/acsa) standards.

With over 40 per cent of NHS trusts/boards in the UK engaged in ACSA, the College’s quality improvement scheme continues to go from strength to strength. The College has visited 33 departments with 18 of these having successfully gained accreditation and 15 more actively working toward this goal. If you are interested in ACSA for your department, please visit www.rcoa.ac.uk/acsa or contact acsa@rcoa.ac.uk to arrange a teleconference or local presentation.

To express an interest in being an ACSA reviewer, email acsa@rcoa.ac.uk. The next training day for reviewers takes place at the College on 12 April 2018 so do get in touch to book your place – we look forward to seeing you.

Be sure to read GPAS Editor Dr Jeremy Langton’s article in this Bulletin (page 15) for more information on GPAS, ACSA and the College’s clinical quality work in 2018. For further information or to engage with the clinical quality team’s work across the UK contact clinicalquality@rcoa.ac.uk.

Over 40 per cent of NHS trusts/boards in the UK are engaged in ACSA
33 departments visited
18 departments accredited

SALG: Patient Safety Update

The Safe Anaesthesia Liaison Group (www.rcoa.ac.uk/salg) (SALG) has issued their quarterly Patient Safety Update, which contains important learning regarding reported anaesthesia-related untoward incidents.

This update [http://bit.ly/salg-psu18] contains anonymous case studies from April to June 2017 and includes items relating to vascular access, delays in care and airway complications. The College would like to bring these updates to the attention of as many anaesthetists as possible, so please read and circulate the document as widely as you can.

ANAESTHESIA 2018

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

The countdown is well underway to our new flagship conference, Anaesthesia 2018 on 22 and 23 May at the British Museum.

Replacing and combining the Anniversary Meeting and Summer Symposium we are attracting internationally renown speakers from across the world including Australia, New Zealand and Singapore. Anaesthesia 2018 is set to offer a truly international perspective on our specialty.

Professor Paul Myles and Professor Mike Grocott will provide delegates with the latest updates and perspectives on perioperative medicine. Professor Jennifer Weller will explore what it takes to build skilled and effective teams, presenting the results of her immersive simulation research.

Delegates can also look forward to a series of quick-fire updates on a range of subjects including obstetric haemorrhage, paediatric airway, acute pain and head injuries.

The two-day conference will close with a lively and informative debate: Professor Tim Cook and Dr William Harrap-Griffiths will go head-to-head to determine if direct laryngoscopes should be consigned to history.

Be part of the conversation and book your place today at www.rcoa.ac.uk/anaesthesia.

#Anaesthesia2018
NIAA’s third Annual Scientific Meeting

Celebrating its 10 year anniversary, the National Institute for Academic Anaesthesia (NIAA) will hold its third Annual Scientific Meeting on Monday 21 May 2018.

This meeting will include updates on the Health Services Research Centre, the UK Perioperative Medicine Clinical Trials Network, and a look back at the NIAA’s achievements as well as its plans for the future.

The NIAA Research Award, which is presented to an active researcher demonstrating excellence in research relevant to anaesthesia, perioperative care or pain, will be a highlight of the meeting.

There’s still (just!) time to apply – the closing date is 5:00pm Monday 8 March http://bit.ly/2mBoXcz

NAP6 Report Launch

The sixth National Audit Project of the Royal College of Anaesthetists (NAP6) will launch its final report at the Royal Society of Medicine on Monday 14 May 2018.

The Baroness Finlay of Llandaff will open what promises to be an engaging and enlightening event. Register at: www.niaa-hsrc.org.uk/NAP6-Report-Launch

NAP6 focuses on perioperative anaphylaxis. While it is rare, it can be life-threatening and lead to serious complications whose epidemiology and clinical impact are incompletely defined. NAP6 has collected comprehensive information concerning perioperative anaphylactic events, enabling the anaesthetic and allergy communities to collaborate in order to make recommendations for the improvement of the quality of patient care. More info can be found at www.nationalauditprojects.org.uk/NAP6home

Disclosure UK

In June 2016 the Association of British Pharmaceutical Industry (ABPI) www.abpi.org.uk launched Disclosure UK http://bit.ly/2D8qSd9, an online database showing payments and benefits in kind made by the pharmaceutical industry to NHS staff including doctors, nurses and other health professionals and organisations in the UK. This includes payments and benefits submitted for collaborations including speaking at and chairing meetings and symposia, training services, and participation in advisory board meetings.

Information published on the Disclosure UK website includes the healthcare professional’s name, their principal practicing address, the payment amount or equivalent benefit in kind, and the name of the pharmaceutical company.

Disclosure data is published annually in June, one year in arrears. Data for 2017 collaborations will be public on Disclosure UK in June 2018. More information can be found on the Disclosure UK website.

British Journal of Anaesthesia and BJA Education

On 1 January 2018, publication of the British Journal of Anaesthesia, BJA Education and the RCAn membership magazine Bulletin transitioned from Oxford University Press to Elsevier.

College fellows, members and non-member subscribers will continue to enjoy delivery of the printed copies, as well as online access to all three publications.

New log in details required

From 1 April, fellows, members and non-member subscribers are required to activate their new online log in details in order to access online journal content. Therefore, prior to 1 April, fellows and members are encouraged to activate their online journal access at either of the two new Elsevier websites: at http://bjanaesthesia.org or http://bjaed.org. This will be a one-time, two-step process which can be found here: http://bit.ly/BJA-BJAed-Access.

If you have questions about creating your new Elsevier online access, or need help to do so, please telephone the Contact Elsevier Customer Support on:
Europe Telephone: +44 (0) 1865-843177 and US and Canada Telephone: 800-654-2452.

NIAA

National Institute of Academic Anaesthesia

Health Services Research Centre

UK PERIOPERATIVE MEDICINE CLINICAL TRIALS NETWORK

Royal Medical Benevolent Fund

The Royal Medical Benevolent Fund (RMBF) www.rmbf.org helps hundreds of doctors, medical students and their family members who are in serious hardship due to age, illness, injury or bereavement.

Offering invaluable support, from financial assistance in the form of grants and loans to a telephone befriending scheme, the RMBF relies on voluntary donations. Your financial contributions can make a real difference to the lives of colleagues and their families in need. If you would like to make a donation visit the RMBF website.
Many patients present for surgery with poorly optimised risk factors, leading to an increased risk of adverse perioperative outcomes. Many of these relate to lifestyle factors (e.g., smoking or inactivity) which are remediable using evidence-based interventions.¹

Current pathways place the onus of patient optimisation on secondary care, leaving limited time to improve patient health preoperatively. Fragmented healthcare delivery creates an environment that leads to patients failing to take opportunities to improve their preoperative health.

Our team
Our team is comprised of clinicians (from primary and secondary care), physiotherapists, academics, commissioners, public health specialists, health trainers and, most importantly, patients! Collaboratively, we have created a new integrated and evidence-based model of care for patients prior to surgery.

The project
PREP-WELL (Figure 1) is a community-based pilot programme designed to improve the fitness, health and wellbeing of patients prior to major surgery. It is funded through a Health Foundation Innovation grant, matched by South Tees Hospitals NHS Foundation Trust, South Tees Clinical Commissioning Group and Public Health Middlesbrough. The programme will recruit 100 patients between January and November 2018, and will be delivered at a Public Health owned ‘Wellbeing Hub’ in Middlesbrough: The LiveWell centre. Patients awaiting surgery are amenable to lifestyle changes – a recognised teachable moment. Combining this with the concept of the ‘aggregation of marginal gains’, we plan to utilise the redundant time between listing and surgery to optimise patient fitness through comprehensive evaluation and targeted interventions. Initially patients will be enrolled from specialties including vascular, upper GI, colorectal, urology and orthopaedics.

Any patient with evidence of unhealthy lifestyle behaviours or co-morbidities on initial screening will be eligible for participation. Patients will undergo an ENTRY evaluation consisting of assess their smoking status, alcohol consumption, fitness, nutritional status, mental wellbeing, quality of life and long-term health problems which are known to impact on perioperative outcomes (e.g., diabetes, frailty, obstructive sleep apnoea, chronic anaemia, etc.). This will include the use of short validated screening tools and review of recent laboratory investigations.
An individualised, comprehensive prehabilitation plan will then be constructed between the patient and the project manager, in this case an experienced physiotherapist, to address identified risk factors. Patient involvement in this ‘target-setting’ stage is crucial for a successful outcome. Some patients may choose to focus purely on improving their aerobic fitness, while others may opt for a comprehensive alteration to their lifestyle. A letter will be sent to the GP, and relevant secondary care clinicians, detailing the prehabilitation plan and highlighting non-optimised long-term health problems. It is hoped that earlier identification of problems will lead to earlier intervention and a better-prepared patient arriving for surgery.

Patients will attend the LiveWell centre twice weekly for six weeks to undertake structured group exercise and access services such as smoking cessation, alcohol reduction and nutritional support. The project manager will co-ordinate individual patients’ plans, with intervention delivery supported by LiveWell centre staff, eg health trainers. Important outcomes will include attendance, enjoyment and exercise progression. Each session will finish with social time and optional group discussion of relevant educational topics relating to forthcoming surgery and longer-term health. Patients will be given supporting information to undertake supplementary additional activity and exercise at home.

Patients will complete the programme as close to surgery as possible to optimise benefits. An EXIT evaluation will be carried out preoperatively, detailing changes in exercise capacity, quality of life, mental wellbeing, chronic health conditions and adverse lifestyle behaviours. Following surgery, patients will be offered access to supervised rehabilitation or home-based guidance. Patients will be asked to complete a health resource diary for 12 weeks following hospital discharge to inform the health-economic evaluation. There will be a follow-up telephone interview to assess sustained changes in lifestyle and quality of life.

PREP WELL has several similarities to the national cardiac rehabilitation programme, and we are working with experts in this field to produce a bespoke database, based on the current IT infrastructure, to allow a standardised dataset to be captured, should our project prove successful and achieve widespread adoption.

Final thoughts
PREP-WELL was designed to align with priorities highlighted in the NHS Five-Year Forward View and the Health Foundation’s Healthy Lives campaign. We believe that our service will be one of the few bringing together the entire timeline (‘before surgery’ through to ‘early after’ and ‘late after surgery’) in our College’s own perioperative medicine vision document (www.rcoa.ac.uk/periopmed/vision_document). We are grateful to the RCoA for the opportunity to showcase this work at a recent New Models of Care event hosted by the Academy of Medical Royal Colleges. We were delighted to be one of only three teams to be named in the summary blog by Louise Watson, the New Care Models programme director!

Reference

Guidelines for the Provision of Anaesthetic Services (GPAS)

A new Editor for GPAS

Dr Jeremy Langton
Consultant Anaesthetist, Plymouth; Editor of GPAS and RCoA Council Member

I was appointed senior lecturer in anaesthesia (honorary consultant) in 1992, and consultant anaesthetist in Plymouth in 1995. I have a long-standing interest in teaching and training, having held a number of roles, including College tutor and RCoA Examiner for 12 years. I was elected as an RCoA Council member in 2012, and I recently served as vice-president (2015–2017).

I am Associate Postgraduate Dean in Health Education South West, with responsibility for specialty training. I have broad editorial experience, having previously been an editor of Anaesthesia, and more recently Editor-in-Chief, BJ A Education (2010–2017).

It is a great honour to be appointed with responsibility for GPAS. This is a key role that is central to RCoA’s GPAS standards provide the foundation for improvements in the care we provide for our patients. I aim to develop closer links between GPAS and ACSA, both within the College and by involving clinicians with ACSA experience in the GPAS chapter-development process, making the standards robust and practical. I also plan to improve the author guidance and to help develop a style guide across all College professional publications.

GPAS will be incorporated into the new College board structures, reporting to Council through the Clinical Quality and Research Board. I plan to further improve GPAS chapters by reducing duplication and overlap between chapters. In addition, within the technology programme, I hope to be able to improve the presentation of GPAS guidelines making them more accessible and relevant to all anaesthetists.
Anaesthesia Clinical Services Accreditation (ACSA)

Thoughts from a first-time ACSA reviewer

Ms Jennifer Dorey
RCoA Lay Committee

In April 2017, I was the lay member of an ACSA review team. The experience was rewarding, enjoyable and informative. After two incredibly busy days, I felt my contribution was very much appreciated and worthwhile.

The ACSA scheme is a voluntary scheme run by the College, benchmarking anaesthetic departments against standards of best practice. The process is structured and supportive, and focused on quality improvement and an ongoing partnership.

Organisations spend several months self-assessing against the ACSA standards, followed by a two- to three-day on-site peer review visit. From the beginning, the scheme has included lay reviewers, working alongside a minimum of two consultant anaesthetists and an administrative reviewer from the College clinical quality team.

I joined the lay committee in April 2016, and was keen to become involved in ACSA. Following a training session explaining the process and practicalities, and participating in a session reviewing one of the Guidelines for the Provision of Anaesthetic Services (GPAS) chapters, I was ready to go.

The College team managing ACSA do a wonderful job bringing together the review team, matching our availability to the review dates, and arranging paperwork, travel and accommodation. Having received the self-assessment document of the department to be reviewed, the review team met (online for us, but sometimes this is in person) to agree which standards to assess and how. We focused particularly on those standards the department had self-assessed as ‘not yet met’, and others we wanted to investigate in more detail or which were of interest to the members of the review team. This resulted in about 70 standards in total. Additional documentation was requested for submission by the department to supplement their self-assessment, and an agenda for the on-site visit was agreed in consultation with the trust’s ACSA lead.

About four weeks later, we all travelled to our hotel and met up over an early breakfast before setting off to the hospital we were visiting. The first morning was mostly spent on presentations from the anaesthetic department and meeting many people – everyone from the porter to the chief executive. ACSA was clearly considered important to the organisation, and they really wanted to tell us their story. Later we had face-to-face discussions with individuals and groups, including senior clinicians, managers, nurses, operating department practitioners and trainee anaesthetists.

After lunch, we set off on a walkabout visiting the different areas of the hospital where anaesthesia is given, which are many and varied. This involved lots of walking and some dressing up in scrubs! At the end of the day we had a debrief meeting with the trust’s ACSA team, we said goodbye and were ready to leave.

The next day was more of the same, but on a different site, looking at pre-assessment, maternity and radiology services, showing us how the anaesthetic service is integrated and delivered across all sites. After another lunch and another meeting with the trust’s ACSA team, we said goodbye and were ready to leave.

Over the next few weeks, the administrative reviewer put together the draft report, and we had several opportunities to comment. The trust had an opportunity to correct any factual aspects of the report. The ACSA report will soon be signed off by the RCoA Accreditation Committee, and will then become the property of the organisation we reviewed. When a department achieves accreditation they receive a plaque during an accreditation ceremony. ACSA accreditation is renewed on a four-year cycle, so continued demonstration of compliance against the standards is required, working in partnership with the RCoA.

Organisations also benefit from contributing to and having access to the ACSA library of good practice, which contains documents and guidance gathered from departments that have participated in ACSA reviews.

The process of an ACSA review is obviously challenging, but certainly seemed to be a catalyst for the anaesthetic team to work together on quality improvement, with real engagement and support from the rest of the trust. I am sure they found it beneficial and even, at times, enjoyable.

The RCoA launched ACSA in June 2013 and there are now 84 departments involved in the process, with 18 having received full accreditation. The vision and hard work involved in getting to this stage are considerable. I feel assured that ACSA is a supportive process, which will improve patient care and experience and spread good practice.

I enjoyed participating in the ACSA review, and felt very much welcomed and appreciated by the other members of the review team and the staff we met. I look forward to my next review and encourage others to get involved.

To find out more about ACSA please visit: www.rcoa.ac.uk/acsa

The RCoA ACSA team can be contacted by telephone (020 7092 1697), or by email at: acsa@rcoa.ac.uk
It has been about a year since our last update regarding the FICM e-portfolio. It has been a relatively quiet year in terms of major changes or improvements. We continue to receive feedback from trainees and trainers, and always try to consider all options within the framework of the e-portfolio with the aim of making the product as user-friendly and educationally beneficial to all as possible.

We understand the issues and burden of having to use two different portfolio systems, and strive to make the product as user-friendly and educationally beneficial to all as possible. The main focus of this last year has been on the future of our e-portfolio. We had been notified some time ago that NES (NHS Education for Scotland), the provider of our e-portfolio, intended to consider all options within the framework of the e-portfolio with the aim of making the product as user-friendly and educationally beneficial to all as possible. We understand the issues and burden of having to use two different portfolio systems, and strive to make the product as user-friendly and educationally beneficial to all as possible.

However, other colleges also use NES e-portfolios, and some of these have elected to look for, and have selected other portfolio providers, which makes the plan to move to version 3 less feasible as there must be enough colleges and faculties moving to the new system to make it cost effective. We are contracted to NES until the spring of 2018, and will sign a fresh contract into 2019. We continue to explore all options available to us with a focus on providing the best product we can for our trainees and trainers within our usual resource constraints. We are currently engaging with two other e-portfolio systems (and their providers): the system the RCoA are developing, and the system which most ex-NES colleges have elected to move to. We will do a full appraisal of these options in the spring, and feed back.

As always, I have some thanks to express. As part of the e-portfolio sub-committee we have two trainee members, Dr Dalyydd Williams and Dr Hywel Garrard. They have come to the end of their two-year term, and I would like to express my gratitude and thanks on behalf of all the e-portfolio sub-committee for all their hard work and engagement with the project, and for bringing a trainee-focused viewpoint to our work.

I would also like to thank the FICM admin team, without whose input and knowledge the e-portfolio would not be as good as it is today. As always, I have some thanks to express. As part of the e-portfolio sub-committee we have two trainee members, Dr Dalyydd Williams and Dr Hywel Garrard. They have come to the end of their two-year term, and I would like to express my gratitude and thanks on behalf of all the e-portfolio sub-committee for all their hard work and engagement with the project, and for bringing a trainee-focused viewpoint to our work.

As always, please contact us with any questions or suggestions for improvement and we will endeavour to reply and address any issue as soon as possible. As always, I have some thanks to express. As part of the e-portfolio sub-committee we have two trainee members, Dr Dalyydd Williams and Dr Hywel Garrard. They have come to the end of their two-year term, and I would like to express my gratitude and thanks on behalf of all the e-portfolio sub-committee for all their hard work and engagement with the project, and for bringing a trainee-focused viewpoint to our work.

It continues to be a great privilege to chair the PSC of the FPM, and I want to thank all members personally for their hard work. The FPM has had a very busy period, with various important national consultations and concerns over long-term opioids in the press. We always strive to ensure that the balance between benefit and harm is properly understood in the media. An opioids working group has been established to manage related work, to provide updates of the Department of Health/FPM Opioids aware publication, and to collaborate with outside stakeholders.

The Dashboard of Clinical Standards has now been successfully tested. This allows units to undertake a self-assessment against existing core standards in pain medicine. We encourage all pain units to use the aid, which is linked to the Core Standards publication which will soon be updated. Further completed publications include:

- checklist for intrathecal pump refills
- document to help professionals advise individuals with chronic pain who drive
- updated medicine information leaflets, including NSAIDS
- updated multi-organisational complex regional pain syndrome (CRPS) guidance
- guidance on extended scope practitioners in pain

Problems with commissioning have been proven to be ineffective, but we provide a voice where evidence has not been interpreted or applied accurately, or where data is inconclusive but there is the potential to impact negatively on patient care.

Finally, thanks again for the huge collective effort of PSC members, who support an increasing but exciting workload.

As always, please contact us with any questions or suggestions for improvement and we will endeavour to reply and address any issue as soon as possible. As always, I have some thanks to express. As part of the e-portfolio sub-committee we have two trainee members, Dr Dalyydd Williams and Dr Hywel Garrard. They have come to the end of their two-year term, and I would like to express my gratitude and thanks on behalf of all the e-portfolio sub-committee for all their hard work and engagement with the project, and for bringing a trainee-focused viewpoint to our work.
Don’t quit!
I’ve worked for over 40 years in and around the NHS, and money has always been tight. But this time the financial pressures seem deeper and more stringent than I’ve ever known.

My greater concern is the seeming lack of a sense of responsibility at the highest levels to find a way through. As I write, another trust chairman has resigned as he does not think the financial regime his trust faces is realistic. Whatever the reasons (and I can hardly imagine the pressures that he and his board face) we cannot afford to lose senior people at such a demanding time. He was an experienced operator – a former Permanent Secretary and boss of several local authorities.

As with trusts up and down the country, there are too many patients, not enough money, too few staff, and a struggling local health economy. His resignation – whatever the circumstances – will do nothing to fill the rota gaps, make the finances stack or stop the queues forming.

What is needed now is leadership. Leaders fight their corner and battle for what they believe is right. They inspire and encourage best practice. They innovate and support new ideas. They are accessible and connect people. They hold the system together.

In its own way, I believe the College has shown some of that leadership. It has developed and supported the implementation of perioperative medicine, which could address some of the pressing issues the NHS faces. Through the Anaesthesia Clinical Services Accreditation scheme, anaesthetic departments can measure themselves against the highest standards and develop services locally.

The College has also raised its profile and image, as well as addressing the governance of the charity. These are a few examples of the continuing leadership required throughout the NHS – in every ward and department.

And for the future? I’m not sure we are getting our heads around the technological developments happening all around us. The College must look to its membership and highlighted the concerns of morale and working conditions.

I admit it will be a hard act to follow, as Rob has expertly led the Committee and enabled us to make a significant contribution to the College’s activities. I would not have been tempted to take it on had it not been for the rest of the Committee being such an experienced and cohesive group. They bring a wide range of experience in many areas, including education, legal, management and pharmacy, which creates interesting discussions and novel insights.

As I am one of the newer members, I may well be unknown to many. I am a retired nurse-lecturer, who has over 30 years’ experience in education and research. Having trained at The Middlesex, now sadly lost in history, I also taught there before as one gets older. Whilst working for King’s College, London I had a clinical attachment to Guy’s and St Thomas’ Hospitals. More than once I found myself in a ward, not that long ago, a student arrived to get her rota and greeted the staff with: ‘By the way, I don’t do evenings or weekends!’ Since when did care become a Monday to Friday, nine-to-five job?

Fortunately I never had to work the now standard 12-hour shift, and I do wonder how wise they are, especially as one gets older. Whilst working for King’s College, London I had a clinical attachment to Guy’s and St Thomas’ Hospitals. More than once I found the nurse in charge having their first tea break at 2.00pm! How one keeps one’s cool and provides quality care when dehydrated and hungry defeats me. However, reports from several sources confirm that front-line staff continue to provide a top-rate service – it’s the getting there that is the problem. Dealing with no or delayed appointments, finding a hospital parking space, and not knowing where to go are just some of the frustrations.

So, as we start afresh in 2018, the lay committee will be supporting ACSA visits and bringing the patients’ perspective to the panel, in addition to all their other roles. Please do not hesitate to contact us if there is any item of work we can help you with.

During March I will be taking over from Rob Thompson as chair of the RCoA lay committee.

I’ve worked for over 40 years in the NHS, and money has always been tight. But this time the financial pressures seem deeper and more stringent than I’ve ever known.

My greater concern is the seeming lack of a sense of responsibility at the highest levels to find a way through. As I write, another trust chairman has resigned as he does not think the financial regime his trust faces is realistic. Whatever the reasons (and I can hardly imagine the pressures that he and his board face) we cannot afford to lose senior people at such a demanding time. He was an experienced operator – a former Permanent Secretary and boss of several local authorities.

As with trusts up and down the country, there are too many patients, not enough money, too few staff, and a struggling local health economy. His resignation – whatever the circumstances – will do nothing to fill the rota gaps, make the finances stack or stop the queues forming.

What is needed now is leadership. Leaders fight their corner and battle for what they believe is right. They inspire and encourage best practice. They innovate and support new ideas. They are accessible and connect people. They hold the system together.

In its own way, I believe the College has shown some of that leadership. It has developed and supported the implementation of perioperative medicine, which could address some of the pressing issues the NHS faces. Through the Anaesthesia Clinical Services Accreditation scheme, anaesthetic departments can measure themselves against the highest standards and develop services locally.

The College has also raised its profile and image, as well as addressing the governance of the charity. These are a few examples of the continuing leadership required throughout the NHS – in every ward and department.

And for the future? I’m not sure we are getting our heads around the technological developments happening all around us. The College must look to its membership and highlighted the concerns of morale and working conditions.

I admit it will be a hard act to follow, as Rob has expertly led the Committee and enabled us to make a significant contribution to the College’s activities. I would not have been tempted to take it on had it not been for the rest of the Committee being such an experienced and cohesive group. They bring a wide range of experience in many areas, including education, legal, management and pharmacy, which creates interesting discussions and novel insights.

As I am one of the newer members, I may well be unknown to many. I am a retired nurse-lecturer, who has over 30 years’ experience in education and research. Having trained at The Middlesex, now sadly lost in history, I also taught there before as one gets older. Whilst working for King’s College, London I had a clinical attachment to Guy’s and St Thomas’ Hospitals. More than once I found the nurse in charge having their first tea break at 2.00pm! How one keeps one’s cool and provides quality care when dehydrated and hungry defeats me. However, reports from several sources confirm that front-line staff continue to provide a top-rate service – it’s the getting there that is the problem. Dealing with no or delayed appointments, finding a hospital parking space, and not knowing where to go are just some of the frustrations.

So, as we start afresh in 2018, the lay committee will be supporting ACSA visits and bringing the patients’ perspective to the panel, in addition to all their other roles. Please do not hesitate to contact us if there is any item of work we can help you with.
An effective educational supervisor will develop a good personal rapport with the trainee over time

For all doctors, undergoing a General Medical Council (GMC) fitness to practice investigation is a worrying and stressful experience. For trainees, there is the added concern of the effect the investigation and any restrictions will have on their progression through training. This article aims to briefly describe how, as a good educational supervisor, you can make all the difference to the trainee with GMC restrictions.

A GMC investigation may involve health, probity, performance or conduct issues, and does not occur in isolation. Due to the wide variety of issues that may arise, doctors involved in investigations may include the employing hospital trust, the National Clinical Assessment Service, the Medical Practitioners Tribunal Service, the GMC, the police, the courts, the deanery/Health Education England, occupational health, and the doctor’s own healthcare professionals. A GMC investigation may involve the employing hospital trust, the National Clinical Assessment Service, the Medical Practitioners Tribunal Service, the GMC, the police, the courts, the deanery/Health Education England, occupational health, and the doctor’s own healthcare professionals.

At the end of the investigation, the GMC may take no action, offer a warning, place restrictions, impose a suspension, or erase a doctor from the medical register. Restrictions are defined as conditions that are imposed on a doctor’s licence to practice, or undertakings that are voluntarily agreed to by the doctor. There are a large number of potential restrictions, which can be found in glossaries on the GMC website. Due to the wide variety of issues that might result in restrictions, and the fact that trainees may be at different stages in the process, the support they need from an educational supervisor will vary widely. It is important therefore that you are aware of the support available to all doctors going through GMC processes. A starting point is the Doctors Support Service run by the British Medical Association (http://bit.ly/289Kx3).

While pastoral care is part of your role as educational supervisor, it is important to be aware that your primary role is to support learning and training on behalf of the deaneries, the RCoA, and the GMC. You are not responsible for co-ordinating the ‘care’ of a trainee in difficulty. Nor is it your role to assess fitness to practice; this is for the GMC. First and foremost, an effective educational supervisor will develop a good personal rapport with the trainee over time. This allows trust to build that will encourage the trainee to speak about the issues that are worrying them. Let them know that you are there to listen, to ensure they have the support they feel they need, and to help them get any further support, in a non-judgemental and confidential way.

Leave it up to the trainee to disclose what they wish about their GMC involvement. The GMC may direct the trainee to provide certain information about any ongoing investigation to their employer, but some details may be confidential, and they may be under no obligation to disclose these to the employer/responsible officer/deanery, particularly if the issues are health related. However, it is important to look together at any GMC restrictions placed on their practice, and these are publicly available via the GMC online List of Registered Medical Practitioners (although restrictions relating specifically to the trainee’s health are not published). Then a discussion should be had about how training will fit into this, how much clinical supervision they require/want, who this might involve, whether they need a phased return to work, whether on-call commitment will be affected, etc. This may require discussion with the College tutor, regional advisor, clinical director, responsible officer, or postgraduate dean. However, any significant alterations to training should have been discussed at deanery level through the annual review of competence progression process as soon as the initial cause for concern was raised.

It is important to have regular meetings, particularly on the trainee’s return to work or at the start of a new placement. The frequency of meetings may be specified as a restriction. Ensure dates and times are recorded, although the details of discussions may be kept confidential. These meetings are likely to be general in nature, focusing on how the trainee is doing and identifying any problems. If you do make records, ensure the trainee understands what detail is kept, who will see it, how it will be stored and how long for, and that they are in agreement with this. You may feel it necessary to inform colleagues about sensitive issues relating to the trainee in order to facilitate adequate clinical supervision. However, this should be kept to a safe minimum, and not be done without the explicit consent of the trainee. You should agree with them what information will be shared, and ensure that all concerned are aware of the need for confidentiality. Navigating these issues can be tricky, and advice can be obtained about record keeping and supervision, without breaching confidentiality from the College tutor, regional advisor or responsible officer.

As a trainee returning to work with restrictions, I know how crucial a good educational supervisor can be. Above all, by listening to the needs of your trainee you can be an effective advocate and significantly reduce their worries about progressing in training through such a difficult time.

Society for Education in Anaesthesia (UK)
Being educational supervisor for trainees with GMC restrictions
by an anonymous trainee

For all doctors, undergoing a General Medical Council (GMC) fitness to practice investigation is a worrying and stressful experience. For trainees, there is the added concern of the effect the investigation and any restrictions will have on their progression through training. This article aims to briefly describe how, as a good educational supervisor, you can make all the difference to the trainee with GMC restrictions.
SAS Specialty Doctors

**SAS LISTENING EVENT**

1 November 2017, Newcastle

The event was attended by five SAS doctors, the president of the College, an SAS Council member and the SAS Committee secretary. The attendees were diverse in their origin: Egypt, Pakistan, India and the UK.

The following themes were identified through the discussion at the SAS Listening Event.

**Accessibility of courses in London**

The physical distance from Newcastle was mentioned as an obvious handicap to attendance at courses in London – mainly because these start quite early in the morning, and an overnight stay in London is usually necessary, with the consequent financial implications. However, the group agreed that London is very well connected and therefore an easy location to reach. A different start time might encourage doctors from the North East to attend courses in London.

**Courses at the RCoA.**

Doctors from the North East to attend different start time might encourage London is very well connected and

However, the group agreed that in London is usually necessary, with

mainly because these start quite early to attendance at courses in London –

The following themes were identified through the discussion at the SAS Listening Event.

**Accessibility of courses in London**

The physical distance from Newcastle was mentioned as an obvious handicap to attendance at courses in London – mainly because these start quite early in the morning, and an overnight stay in London is usually necessary, with the consequent financial implications. However, the group agreed that London is very well connected and therefore an easy location to reach. A different start time might encourage doctors from the North East to attend courses at the RCoA.

**Career development**

SAS jobs may give some doctors the opportunity to enjoy a better work-life balance. However, it can be very difficult for them to access training opportunities. The president mentioned credentialing as a potential future way to recognise their skills, as this is designed for consultants and the SAS workforce. As defined by the General Medical Council (GMC), credentialing is a process which provides formal accreditation of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area. This process is under development, and further details can be found on the GMC website:

http://bit.ly/2m3x1Kk

**Access to the e-Portfolio**

The delegates noted that SAS doctors should be given access to the e-Portfolio.

**Appraisals**

The delegates felt unsure of what is expected from them for appraisals.

**Resources available to help CESR applicants**

- The Regional Advisor Anaesthesia (RAA) can provide SAS doctors with advice on career development within their region. http://bit.ly/RCoA-RAA
- The RCoA has an SAS committee, and can provide formal and informal advice to SAS doctors. sas@rcoa.ac.uk
- The RCoA Bulletin has [at least] one SAS-specific article in each issue. SAS doctors are very welcome to submit articles. If you are interested please email your article to sas@rcoa.ac.uk

**Did you know?**

- The RCoA can provide SAS doctors with general advice on appraisals: http://bit.ly/PAAppraisal. Questions can be emailed to revalidation@rcoa.ac.uk
- The GMC has a wealth of guidance: http://bit.ly/2m-RKvby
- The RAA can provide SAS doctors with advice on appraisals.
- The ‘New to the NHS’ meeting, held annually at the RCoA, has a session on CESR (CESR is not the only option for SAS doctors to develop their careers; there are other educational routes, eg specialised master’s degree).

**Careers and Training in Anaesthesia**

AnnaNaz Arnold, multimodal pain management co-ordinator, Pain Management National Training Centre, Leeds Teaching Hospitals NHS Trust

**Courses at the RCoA.**

Doctors from the North East to attend different start time might encourage London is very well connected and

However, the group agreed that in London is usually necessary, with

mainly because these start quite early to attendance at courses in London –

The following themes were identified through the discussion at the SAS Listening Event.

**Accessibility of courses in London**

The physical distance from Newcastle was mentioned as an obvious handicap to attendance at courses in London – mainly because these start quite early in the morning, and an overnight stay in London is usually necessary, with the consequent financial implications. However, the group agreed that London is very well connected and therefore an easy location to reach. A different start time might encourage doctors from the North East to attend courses at the RCoA.

**Career development**

SAS jobs may give some doctors the opportunity to enjoy a better work-life balance. However, it can be very difficult for them to access training opportunities. The president mentioned credentialing as a potential future way to recognise their skills, as this is designed for consultants and the SAS workforce. As defined by the General Medical Council (GMC), credentialing is a process which provides formal accreditation of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area. This process is under development, and further details can be found on the GMC website:

http://bit.ly/2m3x1Kk

**Access to the e-Portfolio**

The delegates noted that SAS doctors should be given access to the e-Portfolio.

**Appraisals**

The delegates felt unsure of what is expected from them for appraisals.

**Resources available to help CESR applicants**

- The Regional Advisor Anaesthesia (RAA) can provide SAS doctors with advice on career development within their region. http://bit.ly/RCoA-RAA
- The RCoA has an SAS committee, and can provide formal and informal advice to SAS doctors. sas@rcoa.ac.uk
- The RCoA Bulletin has [at least] one SAS-specific article in each issue. SAS doctors are very welcome to submit articles. If you are interested please email your article to sas@rcoa.ac.uk

**Did you know?**

- The RCoA can provide SAS doctors with general advice on appraisals: http://bit.ly/PAAppraisal. Questions can be emailed to revalidation@rcoa.ac.uk
- The GMC has a wealth of guidance: http://bit.ly/2m-RKvby
- The RAA can provide SAS doctors with advice on appraisals.
- The ‘New to the NHS’ meeting, held annually at the RCoA, has a session on CESR (CESR is not the only option for SAS doctors to develop their careers; there are other educational routes, eg specialised master’s degree).

**Careers and Training in Anaesthesia**

AnnaNaz Arnold, multimodal pain management co-ordinator, Pain Management National Training Centre, Leeds Teaching Hospitals NHS Trust

**Did you know?**

- The Regional Advisor Anaesthesia (RAA) can provide SAS doctors with advice on career development within their region. http://bit.ly/RCoA-RAA
- The RCoA has an SAS committee, and can provide formal and informal advice to SAS doctors. sas@rcoa.ac.uk
- The RCoA Bulletin has [at least] one SAS-specific article in each issue. SAS doctors are very welcome to submit articles. If you are interested please email your article to sas@rcoa.ac.uk

**Resources available to help CESR applicants**

- The Regional Advisor Anaesthesia (RAA) can provide SAS doctors with advice on career development within their region. http://bit.ly/RCoA-RAA
- The RCoA has an SAS committee, and can provide formal and informal advice to SAS doctors. sas@rcoa.ac.uk
- The RCoA Bulletin has [at least] one SAS-specific article in each issue. SAS doctors are very welcome to submit articles. If you are interested please email your article to sas@rcoa.ac.uk

**Access to the e-Portfolio**

The delegates noted that SAS doctors should be given access to the e-Portfolio.

**Appraisals**

The delegates felt unsure of what is expected from them for appraisals.

**Resources available to help CESR applicants**

- The Regional Advisor Anaesthesia (RAA) can provide SAS doctors with advice on career development within their region. http://bit.ly/RCoA-RAA
- The RCoA has an SAS committee, and can provide formal and informal advice to SAS doctors. sas@rcoa.ac.uk
- The RCoA Bulletin has [at least] one SAS-specific article in each issue. SAS doctors are very welcome to submit articles. If you are interested please email your article to sas@rcoa.ac.uk

**Did you know?**

- The RCoA can provide SAS doctors with general advice on appraisals: http://bit.ly/PAAppraisal. Questions can be emailed to revalidation@rcoa.ac.uk
- The GMC has a wealth of guidance: http://bit.ly/2m-RKvby
- The RAA can provide SAS doctors with advice on appraisals.
- The ‘New to the NHS’ meeting, held annually at the RCoA, has a session on CESR (CESR is not the only option for SAS doctors to develop their careers; there are other educational routes, eg specialised master’s degree).

**Careers and Training in Anaesthesia**

AnnaNaz Arnold, multimodal pain management co-ordinator, Pain Management National Training Centre, Leeds Teaching Hospitals NHS Trust

SAS doctors represent 22 percent of the anaesthetic workforce. The aim of the Listening Event held on 1 November 2017 was to better understand their needs and how the College can support them. This event was held in Newcastle, following previous events in other locations.

The event was attended by five SAS doctors, the president of the College, an SAS Council member and the SAS Committee secretary. The attendees were diverse in their origin: Egypt, Pakistan, India and the UK.

The following themes were identified through the discussion at the SAS Listening Event.

**Accessibility of courses in London**

The physical distance from Newcastle was mentioned as an obvious handicap to attendance at courses in London – mainly because these start quite early in the morning, and an overnight stay in London is usually necessary, with the consequent financial implications. However, the group agreed that London is very well connected and therefore an easy location to reach. A different start time might encourage doctors from the North East to attend courses at the RCoA.
Engaging with emergency laparotomy patients

It is increasingly recognised that patients should be actively engaged not only with the decision-making process for their own care but also with shaping the provision of services. Therefore, the National Emergency Laparotomy Audit (NELA) will be reflecting this over the coming years in several ways, helping to ensure that care reflects what patients actually need, want and deem important.

Similarly to patient and public involvement (PPI) for research projects, NELA is now committed to actively engage patients through consulting them (not simply informing them) about the future direction of the audit, the questions we ask, and the reports we write. Collaborative working between clinical staff at local level and emergency laparotomy patients may help underpin effective and sustained quality improvement work to better ensure a positive impact on patients’ perception of their overall care.

However, there are challenges. NELA collects data on a heterogeneous patient population aged from 18 to 105 years presenting for surgery for many different indications. PPI work needs a representative group of patients to engage in co-production and co-design initiatives. Patients may be reluctant to participate as their opinions may be seen as challenging the professionalism or expertise of clinicians who looked after them at a vulnerable time. Additionally, the majority of emergency laparotomy patients are high risk, and they may have associated negative emotions and anxiety when recalling their experiences which may dissuade them from joining patient support or focus groups.

Efforts to engage patients and their families must ensure that appropriate reassurance and support is available, together with clear descriptions of their roles and responsibilities when participating in PPI activity. How NELA helps: shared decision-making and discussion of risk

NELA provides a bespoke risk tool designed specifically for emergency laparotomy patients. We encourage clinicians to use this to support multidisciplinary discussions to ensure that the best care is given by the right teams in the right location at the right time. Objective risk stratification tools are also useful in quantifying risk as part of informed consent. As clinicians, we should ensure that the risks and benefits of surgery can be understood by patients and their families in a timely manner.

Patient support groups and patient-reported outcome measures (PROMs)

Patient support groups are well established within the specialties for chronic diseases such as cancer or diabetes. They usually take the form of regular meetings between patients, and provide opportunity for peer support from other patients with similar health experiences, and sometimes education particular to them. As yet, there is no national formal support network, charity or action group established for emergency laparotomy patients. However, some hospitals are now providing support groups and using the NELA dataset to engage patients and their families. Ultimately, once this area has developed, the aim would be to create a system of co-production of emergency laparotomy care.

PROMs have so far concentrated on elective surgery or chronic conditions. The validity of asking preoperative questions in emergency situations is less well understood, and NELA has recently supported (in conjunction with the London School of Hygiene and Tropical Medicine) a feasibility study on the collection of PROMs in emergency laparotomy patients, the results of which will soon be published. This should help in the understanding of the longer-term impact of emergency laparotomy – an area in which there is little reported.

Patient information leaflets

Well-designed information leaflets help patients understand their surgery, and are well utilised for elective procedures. The challenge in the case of emergency laparotomy is the urgent nature of surgery, coupled with patients being too unwell to read any information. Therefore, it may also be useful to provide postoperative ‘debriefing’ leaflets to answer common questions. Information could be provided to families who may have had little time to ask questions or understand the wider context of the care being delivered to their loved ones. To address this need, NELA will be increasing the existing patient information about the audit by adding patient information leaflets and creating a website section specifically for patients.

NELA reports for patients

NELA will publish an annual patient report in a format that is relevant and understandable. NELA will also publish hospital performance information in a patient-friendly manner that the public can easily access.

NELA would particularly like to hear from teams who are interested in collaborating to develop and run local patient support groups, or develop patient information leaflets. Please contact us at info@nela.org.uk.

References
7. London School of Hygiene and Tropical Medicine. www.lshtm.ac.uk.

Dr Sarah Hare
National Clinical Lead, National Emergency Laparotomy Audit (NELA)
Perioperative Quality Improvement Programme (PQIP)

PQIP is one year old – are you involved?!

The Perioperative Quality Improvement Programme (PQIP) is a multidisciplinary initiative aiming to reduce postoperative complications and improve patients’ outcome, experience, and quality of life. It is a research study being led by the NIAA Health Services Research Centre, using innovative methods to drive improvement. It is also on the NIHR portfolio (which means hospitals can get research-nurse support to take part).

PQIP captures and systematically feeds back evidence-based process measures (i.e. what we do to patients), morbidity data (complications), and patient-reported outcomes (such as satisfaction, and longer-term quality of life up to a year after surgery), as well as more commonly used measures of quality such as 30-day mortality. We are also tracking long-term patient outcomes, including disability-free survival at one year, in order to be able to better understand the full impact of surgery and perioperative care.

PQIP has so far been adopted by over 70 hospitals, and we are aiming to recruit 70,000 patients over the next few years. Eligible patients are those undergoing selected major non-cardiac procedures. Each hospital is aiming either to recruit all patients undergoing eligible procedures, or to recruit a random sample of up to five adult patients per week. Data is collected on patient-risk factors, processes of care, and a range of outcomes, via an online webtool. The online system offers near real-time feedback via online dashboards on metrics such as the proportion of patients undergoing preoperative assessment, proportion of patients ‘DrEaMing’ (drinking, eating and mobilising), and how many patients have morbidity on day seven after surgery (Figure 1). Hospitals also receive quarterly reports on the measures recorded over the last three months. This also includes a set of Microsoft PowerPoint slides allowing the data to be distributed to colleagues.

So, what are we trying to achieve through PQIP? The first and most important aim is to improve the quality and outcomes of care for patients undergoing major elective surgery. The mechanism for achieving this is the provision of high-quality data on processes and outcomes to local teams in easily accessible formats, so that they may then use this information to drive local quality improvement. Additionally, PQIP can be seen as a learning opportunity for all members of the multidisciplinary team – the website (www.pqip.org.uk) is full of free resources such as quality improvement (QI) training guidance, research papers which can be used for journal clubs, and videos and podcasts about QI, surgical outcomes and perioperative medicine. We will also hold our first collaborative meetings for their own data to analyse and drive local research and improvement efforts.

In particular, PQIP presents a massive opportunity for trainees. Engagement with PQIP should mark the end of the pointless quick audit which is hurriedly carried out in order to satisfy the ARCP panel. The routine collection of a huge amount of data about key processes (e.g. enhanced recovery compliance and preoperative risk assessment) and linked outcomes (e.g. inpatient complications, recovery room indicators such as temperature and pain, and anaesthesia-related indicators such as thirst, postoperative nausea and vomiting, and confusion) means that trainees can invest their valuable time in designing and delivering the improvement projects, which will be of most value locally. We are also working with RAFT (Research and Audit Federation of Trainees) and TriPOM (Trainees with an interest in Perioperative Medicine) to develop more ideas about how to engage with trainees.

There are many opportunities to be involved in PQIP. If you would like more information please visit www.pqip.org.uk or contact the team pqip@rcoa.ac.uk or follow us on twitter @pqipnews

We are very keen to listen to your views, so please get in touch with us if you have any feedback on PQIP, or ideas about how to improve it.

Figure 1 An example of a dashboard available online looking at the Postoperative Morbidity Score
Clouonal Directors’ National Executive Committee

The Clinical Directors’ Network

In 2010, Dr Peter Nightingale, as the president of the College, approached Dr Mike Nevin to develop a network of medical leaders who had a major commitment and managerial responsibility to anaesthesia, critical care and pain management. This became the Clinical Directors’ Network.

Its initial aim was to help inform the College’s decision-making process, taking into account the Clinical Directors’ perspective, and considering the wider impact of decisions or proposed change on the whole range of service provision, including quality of care, training, recruitment and financial implications. The chairman of the Network was co-opted to College Council, and there is now representation on the majority of major College committees.

In 2013, a Clinical Directors’ Executive Committee with eight members was established, ensuring representation across all four UK nations, and a deputy chair was appointed. The Executive Committee has recently recruited three new members, and has also refreshed and purged the Clinical Directors’ database, which now contains 225 members who have a major managerial commitment. The Network has a secure area on the College website, which is being further developed in conjunction with the Technology Strategy Programme. It contains a confidential bulletin board for advice, a resource library, and records of Network executive members’ biographies and Network members’ contact details.

Two joint AAGBI/RCoA National Clinical Directors’ meetings are held each year, and attract over 100 delegates. Discussion topics at these meetings range from recruitment and retention, procurement and efficiency to responses to recent major terror attacks. There is also a joint annual Clinical Directors/Regional Advisors Anaesthesia meeting. Later this year the Network will be hosting the first regional Clinical Directors’ meeting, with the aim of increasing engagement from departments outside the capital. From December 2017, representation from the Network has additionally been co-opted to the Council of the AAGBI.

In the next article we plan to introduce members of the Executive Committee, who will describe their leadership journey and discuss some common management challenges.

Revalidation for anaesthetists

Extracts from the CPD quality assurance report

Chris Kennedy
RCoA CPD and Revalidation Co-ordinator

Chris Kennedy
RCoA CPD and Revalidation Co-ordinator

Around this time each year, the Bulletin includes some extracts from the quality assurance report for the CPD approval scheme at the College, which is produced for the CPD board.

The latest quality assurance report covers the period from 1 November 2016 to 31 October 2017, during which details of 1,199 events were submitted to the College for CPD approval – an increase of 44 on the number of applications in the previous 12-month period. The majority of applications received were targeted at a ‘national’ audience, and most events were being held in London, closely followed by the South East and West Midlands regions.

Of the applications received, 1,019 were unconditionally approved for the CPD credits applied for, whilst 138 were only approved when further information had been supplied from the event provider – for example, clarification on the programme timings or ‘mini biographies’ of the event faculty demonstrating their experience to deliver the subject matter. A total of 42 applications were not approved for CPD, for reasons that included the inappropriateness of the event or its content for career-grade doctors or for our specialty.

The event evaluations were completed by 74 CPD Assessors – who included nine members of the CPD board, and nearly 69 percent of the CPD Assessors completed their evaluations within an average two-week time frame. It would not be possible to run the CPD approvals scheme without the time, support and expertise provided by all the CPD Assessors, and we are extremely grateful to them all.

The report details the annual review of delegate feedback from a sample of CPD-approved events, with 125 items of feedback reviewed and some novel approaches described, and it gives information on which codes from the CPD Matrix were covered in CPD-approved events. It is hoped that this data, together with the information on the regional locations of CPD-approved events, will be helpful for event providers. The report also details some of the CPD resources which are available, including an update on the College-wide Technology Strategy Programme.

The report is available in the CPD section of our website, or for any further information please contact cpd@rcoa.ac.uk.

In 2010, Dr Peter Nightingale, as the president of the College, approached Dr Mike Nevin to develop a network of medical leaders who had a major commitment and managerial responsibility to anaesthesia, critical care and pain management. This became the Clinical Directors’ Network.

Its initial aim was to help inform the College’s decision-making process, taking into account the Clinical Directors’ perspective, and considering the wider impact of decisions or proposed change on the whole range of service provision, including quality of care, training, recruitment and financial implications. The chairman of the Network was co-opted to College Council, and there is now representation on the majority of major College committees.

In 2013, a Clinical Directors’ Executive Committee with eight members was established, ensuring representation across all four UK nations, and a deputy chair was appointed. The Executive Committee has recently recruited three new members, and has also refreshed and purged the Clinical Directors’ database, which now contains 225 members who have a major managerial commitment. The Network has a secure area on the College website, which is being further developed in conjunction with the Technology Strategy Programme. It contains a confidential bulletin board for advice, a resource library, and records of Network executive members’ biographies and Network members’ contact details.

Two joint AAGBI/RCoA National Clinical Directors’ meetings are held each year, and attract over 100 delegates. Discussion topics at these meetings range from recruitment and retention, procurement and efficiency to responses to recent major terror attacks. There is also a joint annual Clinical Directors/Regional Advisors Anaesthesia meeting. Later this year the Network will be hosting the first regional Clinical Directors’ meeting, with the aim of increasing engagement from departments outside the capital. From December 2017, representation from the Network has additionally been co-opted to the Council of the AAGBI.

In the next article we plan to introduce members of the Executive Committee, who will describe their leadership journey and discuss some common management challenges.
Making sense of perioperative medicine training

Dr Henry Lewith
ST5, Buckinghamshire Healthcare NHS Trust

Dr Carl Morris, Consultant Anaesthetist, Buckinghamshire Healthcare NHS Trust
Dr Caroline Pritchard, Consultant Anaesthetist, Buckinghamshire Healthcare NHS Trust

Since August 2016, perioperative medicine is a compulsory unit of training for all levels of anaesthetic training. We found both trainees and trainers though, are sometimes unsure how this should be achieved.

Perioperative medicine training

Perioperative medicine, ‘sets out a vision for development of the specialty of anaesthesia to improve patient care in the period before, during and after surgery’. The training unit is organised into preoperative, intraoperative and postoperative sections. It is designed to integrate with existing training, allowing a flexible approach to achieving competencies, without compromise to the rest of the clinical curriculum. Training can be delivered in both district general hospital (DGH) and teaching hospital settings.

Creating a training module

Buckinghamshire Healthcare NHS Trust has over 20 anaesthetic trainees working across two DGH sites. Surgical specialties include acute and elective, major plastic, colorectal, urology and orthopaedics, with an innovative preoperative assessment training module. So no shortage of opportunities to fulfil the curriculum requirements.

But how to make the most of these opportunities? This was the question I was faced with when I was asked by my college tutor to create a unit-of-training guide for the anaesthetic department.

The first step was to identify a lead for perioperative medicine. Our department’s existing preoperative assessment lead took this on. Together, we spent several weeks reviewing the curriculum, condensing a clear set of objectives and learning outcomes, and identifying how they could be achieved. We established what learning opportunities were available and how best to access them. We realised that there was a lot of information and resources, but little in the way of organisation.

To remedy this we focused on three main areas.

First, we created a trainee handbook, putting in one place all the module information, assessment requirements, and national and local clinical policies. This made it possible for trainees to better understand the module and gain benefit from it, providing up-to-date resources, relevant clinical papers, policies and research.

Second, we identified non-anaesthetic training opportunities and made arrangements for trainees to attend. These included working with orthogeriatric teams, postoperative surgical reviews and attending high-risk echocardiogram and respiratory clinics. Senior trainees were also able to attend high-risk obstetric clinics. These were important resources allowing trainees to develop their knowledge of anaesthetic management and appropriate preoperative investigations.

Finally, we created a timetable, highlighting appropriate surgical lists, preoperative clinics and non-anaesthetic teaching. This made it easy for trainees to maximise their time, and not miss beneficial learning opportunities.

Creating a new assessment

As the perioperative module was to run with achievable workplace-based assessments, alongside existing training, attendance at a preoperative clinic was not compulsory (although it was strongly recommended). But to ensure that the key concept of perioperative medicine – connecting the care before, during and after surgery – was assessed, we developed the concept of an ‘Index Case’.

Trainees were expected to identify a patient with a significant co-morbidity (cardiovascular, renal or respiratory) undergoing a complex surgical case. They were required to review the patient in the preoperative setting and identify modifiable risk factors, assist the anaesthetic management of the case, and review the patient postoperatively with the surgical teams, identifying any early complications.

The ‘Index Case’ became the cornerstone of our perioperative module, allowing trainees to link all areas of anaesthetic management together.

Implementing a training module

Once we had created the training module, I sat down with the anaesthetic trainees during teaching sessions and departmental induction to explain these key concepts and requirements. All trainees and consultants were given the handbook and timetable electronically, with hard copies available at each clinical site.

Giving the consultant body the handbook also ensured that there was consistency throughout the department on what was expected from the trainees. It was also important that the rota coordinator understood the module, as some trainees required rota changes to complete their index case.

Further developments

This module was implemented as a pilot scheme, and further developments are planned. More clinics are being arranged, and all trainees will be allocated time to allow them to identify high-risk patients and view assessments such as cardio-respiratory exercise and respiratory function testing. A trainee lead for perioperative medicine will also be identified. This will allow regular review of the timetable and handbook, and ensure a link between the anaesthetic department and non-anaesthetic clinics.

Implementing in other hospitals

We found that the handbook and timetable were very popular with both trainees and consultants for both clinical and exam knowledge. The ‘Index Case’ ensures that trainees develop experience and knowledge linking all three areas of anaesthetic care.

Perioperative medicine can be taught well in any hospital setting. In the pilot we achieved this through enthusiastic and knowledgeable consultant and trainee leads who identified learning opportunities and outcomes, and shared these effectively with the anaesthetic department.

References

The very slow march to a paperless NHS

Dr Krish Ramachandran
Consultant Anaesthetist, Warwickshire and
RCoA Council Member

Table 1 Pros and cons of electronic records

<table>
<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information at the point of care.</td>
<td>Very expensive.</td>
</tr>
<tr>
<td>Efficiency improved.</td>
<td>High-speed internet essential.</td>
</tr>
<tr>
<td>Increased productivity.</td>
<td>Training required.</td>
</tr>
<tr>
<td>Legible notes.</td>
<td>Data-security concerns.</td>
</tr>
<tr>
<td>Efficient sharing of information.</td>
<td>Less flexible.</td>
</tr>
<tr>
<td>Facilitates research and audit.</td>
<td></td>
</tr>
<tr>
<td>‘Endless’ storage possible.</td>
<td></td>
</tr>
<tr>
<td>Cost savings – long term.</td>
<td></td>
</tr>
</tbody>
</table>

In the last decade or so EPR has been widely adopted in primary care, but secondary care has lagged well behind. Whilst the advantages of EPR are clearly evident, these are counterbalanced by some serious challenges, which explains the wide discrepancy in its implementation. It is therefore pertinent to address these challenges and look at possible solutions.

Finance remains the main impediment, as it costs each trust several million pounds to fund the transition to EPR. A few financially stable trusts have faced the challenge head-on, and in 2016 NHS England released a list of a dozen acute trusts that will receive up to £10 million each to serve as ‘digital exemplars’ for the health service. But, in the absence of any external support, the only realistic option for the majority is to upgrade existing digital systems.

Concerns about data security have been brought into sharper focus by cyber attacks that have not spared even secure institutions like banks. Whilst these attacks principally affected organisations that ignored warnings and failed to invest in the latest security software, Robust IT governance/infrastructure, including staff training, should mitigate the effects of these attacks.

Staff engagement is a critical factor for success! After all, who likes change? Aging hardware and crawling internet speeds are all too common, adding to the frustration. Overhauling outdated IT systems and ensuring that systems are more user-friendly will go some distance towards gaining staff cooperation.

‘Interoperability’, or communication between different IT systems, is crucial, as integrated care remains the ultimate goal! With countless systems and programmes in operation, interoperability will offer a mammoth challenge, further adding to mounting woes.

AIMS not being integral to EPR will incur additional investment. It is almost impossible for any anaesthetic department to make the transition to electronic records without support from trust management, and this calls for representation at the highest level to ensure that our voices are heard.

The advantages of AIMS are similar to the findings of the Wachter review, which recommends moving the deadline to 2023.1 Given this evolving digital landscape, it is worthwhile revisiting the subject of the EPR and the Anaesthetic Information Management System (AIMS), previously aired in an article published in the Bulletin in April 2011.

Not that my typing skills are great, but my handwriting is chicken scrawl. And to think I was brought up writing long essays! Naturally, I was excited at the prospect of not having to put pen to paper – literally. But, my joy was dealt a body blow when the controversial ‘Connecting for Health’, the programme for an integrated electronic patient record (EPR), was declared a failure in 2011. Since then the project has witnessed frequent shifts in goals and deadlines – 2020 being the latest. The 2016 King’s Fund report described the new target as unrealistic because of lack of clarity over funding.1 It endorsed instead the aspiration for a little while longer.

When the NHS announced its intentions to go ‘paperless’ in 2002, I was among the many that welcomed the move. Amongst my sound arguments for supporting a digital health service, lies one embarrassing reason – my illegible handwriting.

In the end, it appears that the EPR juggernaut is rolling forward, albeit at a much slower pace than originally planned. The case for AIMS is less assured. With lack of funds and a dampened enthusiasm amongst colleagues, AIMS will remain an aspiration for a little while longer.

References

Musings of a jobbing anaesthetist on the RCoA Council

When the NHS announced its intentions to go ‘paperless’ in 2002, I was among the many that welcomed the move. Amongst my sound arguments for supporting a digital health service, lies one embarrassing reason – my illegible handwriting.

In the last decade or so EPR has been widely adopted in primary care, but secondary care has lagged well behind. Whilst the advantages of EPR are clearly evident, these are counterbalanced by some serious challenges, which explains the wide discrepancy in its implementation. It is therefore pertinent to address these challenges and look at possible solutions.

Finance remains the main impediment, as it costs each trust several million pounds to fund the transition to EPR. A few financially stable trusts have faced the challenge head-on, and in 2016 NHS England released a list of a dozen acute trusts that will receive up to £10 million each to serve as ‘digital exemplars’ for the health service. But, in the absence of any external support, the only realistic option for the majority is to upgrade existing digital systems.

Concerns about data security have been brought into sharper focus by cyber attacks that have not spared even secure institutions like banks. Whilst this is deeply worrying, how many of us would want to see a return to old-style drug syringes, it will drastically bring down drug errors too. Artifacts are an annoyance, but several departments already use printers to record data, and, one suspects they will not want to revert back to handwritten records.

Finally, integrating AIMS with EPR will facilitate sharing of information with other professionals, and this will serve as a reference for future anaesthetic episodes.

In the end, it appears that the EPR juggernaut is rolling forward, albeit at a much slower pace than originally planned. The case for AIMS is less assured. With lack of funds and a dampened enthusiasm amongst colleagues, AIMS will remain an aspiration for a little while longer.
The Cappuccini test

Since 2014, and following the recommendations of the Francis report, it has been NHS policy that all hospital patients have a named consultant responsible for their care; the identity of this ‘responsible consultant’ should be prominently displayed above the bed. In anaesthesia, we have had a similar policy for many years, with a national audit standard that 100 percent of trainees must have immediate access to consultant advice or assistance.

This is clearly important in a specialty where life threatening complications can occur with little warning even during the most straightforward procedure, but such supervision is impossible if (a) the trainee does not know who is supervising them or (b) the consultant does not know who they are supervising. Failure to have clear-cut and robust routes to senior help in anaesthesia can have disastrous results.

Dr David Bogod
Consultant Obstetric Anaesthetist, Nottingham and RCoA Council Member

Frances Cappuccini was a primary school teacher who in October 2012 had a postpartum bleed following the Caesarean delivery of baby Giacomo. She was taken back to theatre under the care of a junior SAS anaesthetist, whose practice had already been the subject of trust scrutiny. Subsequently, one of the key findings of the coroner was that ‘The supervision arrangements in respect of [the anaesthetist] were undefined and inadequate and no-one was aware who was supervising him and their availability’.

This is not an isolated example. I have been struck in recent years, sadly too often at inquests, how lack of adequate supervision is often the precipitating factor leading to severe patient harm or death. This happens, in my experience, just as much in large teaching hospitals as it does in district general hospitals. It is likely that a major reason for this inadequacy of staff numbers and increasing emphasis on Lean methods of working that do not leave capacity for supervisory cover. After all, it is axiomatic that a consultant supervising a trainee in another theatre must themselves have competent cover to enable their own patient to be cared for when their expertise is required elsewhere. Rapid turnover of staff, reliance on short-term locum cover, and high levels of sick leave must also play their part in increasing the risk that a doctor working alone on a complex case can go unrecognised and unsupported.

As a consequence of these cases, and in order to explore, uncover and rectify gaps in supervision, I am proposing a very simple test which can be carried out as a recurrent audit by clinical staff. I am delighted that I have had a very positive response from Frances’ family to my suggestion that this be named ‘The Cappuccini Test’. As well as a fitting memorial to a patient who was comprehensively failed by the NHS, the name will, I hope, stimulate future generations of doctors to explore the case that lies behind the test and, the media being what they are, will facilitate publicity for it.

The Cappuccini Test lends itself particularly well to anaesthesia, but with a little imagination could be rolled out to other specialties as well. If your relative was receiving complex multidisciplinary hospital care, you would want to know which specialist was ultimately responsible for each aspect of that care. Our patients deserve no less.

The Cappuccini Test works as follows. Over a period of perhaps one week, junior and non-autonomous SAS anaesthetists identified from the rota are working alone are approached and asked two questions:

1. Who is supervising you?
2. How do you get hold of them?

The answer to question 2 is then used to contact the named supervisor, who is in turn asked:

3. Who are you supervising?
4. What are they doing at the moment?

1. I w...
New membership service to attract the next generation of anaesthetists

With part of the College’s five year strategy focusing on supporting anaesthetists throughout their career, in November 2017 the College launched a new membership service for medical students and foundation year doctors.

At the time of writing in January, the College has received 104 applications for this new membership category. This encouraging response is a clear indication that medical students and foundation year doctors see membership of the College as a positive way to be supported in a potential future specialty. This is the first College membership offering to medical students, so it has been pleasing to see such a positive reaction.

Membership offers support for those interested in learning more about anaesthesia as a specialty, and it is hoped that they will be encouraged to pursue a career within anaesthesia, pain medicine and intensive care.

Why open membership to medical students and foundation year doctors?

Implementing a new membership service for medical students and foundation year doctors has a number of advantages and benefits for the specialty, for applicants and for the College.

It is vital that the College stays modern, relevant and competitive by offering support and guidance to a potential future generation of anaesthetists and intensivists. While anaesthesia remains a popular specialty, the College has a role in continuing to raise the profile of our specialty and in providing ease of access into anaesthesia at an early stage of a doctor’s career.

Understanding members’ needs

In order to understand the membership needs of medical students and foundation year doctors, the College hosted a series of focus groups in spring 2017. An interest in pursuing a career in anaesthesia and wanting to gain increased exposure to the specialty, were the main reasons given in feedback from medical students and foundation year doctors for being interested in College membership.

This feedback helped shape the benefits package on offer, with the majority of the membership benefits focusing on supporting applicants in applying for training, getting information about careers in anaesthesia, and about the latest news and events relating to the specialty.

Dr Clare van Hamel, Severn Foundation School Director and Clinical Advisor to The Foundation Programme, who contributed to the focus groups, said, ‘Although anaesthetics has generally remained a popular specialty choice, foundation year doctors have shown they welcome the opportunity for early contact with the College. They anticipate it will enable them to better understand and prepare for a career in anaesthetics.’

Kelechi Ike, a medical student, based in Romford, Essex, who joined in December, said: ‘Taking advantage of the College’s new membership service for medical students just made sense! Anaesthesia is a specialty with a plethora of avenues within to choose from, and to do so without guidance would be near impossible. I look forward to attending discounted events with the RCoA and also being able to use the e-Learning page on their website.’

Membership benefits

As part of the membership benefits package, students and foundation year doctors will receive:

■ 75 percent discount on select RCoA events*
■ opportunities for RCoA sponsorship of medical fairs and events**
■ College publications, including the Bulletin magazine, and the President’s News monthly e-newsletter
■ webcast access – video recordings of lectures (including lecture slides) from selected RCoA events (www.rcoa.ac.uk/webcasts)
■ networking opportunities with other anaesthetists and students
■ use one of medicine’s largest interactive online learning resources in the UK – RCoA e-Learning Anaesthesia (e-LA) (www.rcoa.ac.uk/e-LA). This is an interactive learning resource which includes online lectures to provide you with vetted material to complement your practical learning
■ National Union of Students (NUS) card (the number one student discount card).***

* There will be a limited number of places available at a 75 percent discount at selected RCoA events.
** While this is open to non-members, priority will be given to members.
*** For medical students only.

The cost of foundation membership is just £3 per month and £10 per year for medical students. For more information, visit the website: www.rcoa.ac.uk/career-in-anaesthesia
Improving trainee choices in anaesthetic recruitment

Dr Rachel Ford
ST6 Wessex and trainee representative on the RCoA Recruitment Committee

Dr Justine Elliott
ST7 Imperial and trainee representative on the RCoA Recruitment Committee

Mr Tom Melia, Anaesthetic National Recruitment Office (ANRO)
Dr Tom Gale, Chair, RCoA Recruitment Committee

The selection of doctors who will flourish in the anaesthetic training programme and be the future of the anaesthetic workforce is vital. The processes for anaesthetic recruitment are currently undergoing significant change.

Why change?
The primary drivers for change are the improvement of the trainee experience and broadening their choice of posts. In the 2016 junior doctors’ contract, Health Education England committed themselves to streamlining recruitment to all specialties. This will involve moving away from local recruitment to national processes, and most specialties will move to a single-transferable-score system. Reducing the number of Selection Centres may improve efficiency and reduce costs. The RCoA Recruitment Committee has engaged with a wide variety of key stakeholders across the UK to consider methods to improve trainee choice and increase standardisation at Selection Centres.

The new recruitment model
England, Wales and Northern Ireland have opted to use the single-transferable-score system. Applicants will have one interview at a Selection Centre of their choosing. They will undergo the current ‘three-station’ interview, resulting in a score out of 200, which will be used to rank individual applicants nationally. Applicants will be able to express their preferences for all posts within England, Wales and Northern Ireland, with posts offered on the basis of each applicant’s national ranking.

Scotland has opted out of the single-transferable-score system, and will continue to conduct its own interviews and offers process. Trainees applying for posts in Scotland will be interviewed and considered within Scotland initially. Those unsuccessful in gaining a post will be entered into the national clearing process.

Applications
The application process is largely unchanged; applicants apply using the Oriel portal (see the ANRO website) and complete the self-scoring framework as part of their application. Applicants can opt to apply to the single transferable score area or to Scotland. Once their application has been accepted, they can express preference for as many posts as they like, but should only do this for posts that they would be willing to accept. Applicants will be able to modify their preferences until the national upgrade deadline.

Selection Centres
In an effort to streamline the interview process, Selection Centres will no longer be located in each local office. There will be up to ten Selection Centres with one each in Northern Ireland, Wales and Scotland, and a number of them across England. The schools of anaesthesia within each geographical area will be collaborating to facilitate interviews at each Selection Centre.

The Selection Centre configuration and scoring remains unchanged, with each Centre comprising three ‘stations’:

- a portfolio station which includes time for review of each applicant’s portfolio self-score, and assessment of reflective practice, commitment to anaesthetics, and organisation
- a presentation station
- a clinical interview station.

The scoring by each assessor is independent, and will be carried out using a digital scoring system, allowing increased accuracy and efficient collation of results to the national office.

A considerable amount of work has been undertaken to ensure that the trainees’ experience is uniform across Selection Centres, including the use of:

- mandatory online training and benchmarking for assessors
- peer and lay review of interview centres
- standardised briefing for all assessors and applicants on the day of interviews.

Offers
Offers will be made via the Oriel portal, with posts being offered in ranked order based on individual scores. Trainees have 48 hours to accept, hold or decline their offer. They will have three options:

- accept – offers can be accepted outright or with the option to upgrade. The upgrade system allows trainees to be automatically offered their preferred posts if they become available. Once a trainee accepts a post in anaesthesia their applications to other specialties in the same round will be withdrawn
- declined – posts declined will be re-offered down the ranking to the next appropriate applicant. Applicants who decline an offer will receive no further offers in the specialty recruitment round
- hold – applicants who are applying to a number of specialties may wish to hold a post until the results of other specialty applications become available. A final decision on held offers must be made by the national deadline.

Feedback
All applicants will receive quantitative and written feedback during the ‘offers’ stage of the process.

Clearing
Clearing can still occur if there are appointable applicants and vacant posts. Any applicants eligible for clearing will be contacted by ANRO. Applicants who fail to reach the minimum appointable score will be ineligible for clearing.

Further information
Detailed information for trainees is available via the ANRO website: https://anro.wm.hee.nhs.uk

Reference
A name Manchester will never forget

Dr Russell Perkins
Consultant in Paediatric Anaesthesia, Manchester and RCoA Council Member

So many great things and people have come from my adopted city: from the industrial revolution and the women’s suffrage movement to matchstick men and Morrissey. It is where I have lived and worked for 25 years, and where my children were born and grew up.

After the mindless, wanton violence perpetrated against young people at the end of a concert at the Manchester Arena in May 2017 my admiration for this great northern city and its people has been firmly cemented into my heart. The selfless gestures of help from bystanders, the taxi drivers offering free journeys home and the locals offering overnight shelter to total strangers. But for me, above all of that, was the work done by the emergency services and in all of the hospitals across Greater Manchester. We are lucky to have several world-class hospitals, all within a few miles of the Manchester Arena, and many other excellent large district hospitals further afield. Colleagues and friends worked tirelessly throughout that night and for many more days and nights afterwards. It is only later that I realise it has been my privilege to have been trained by, or to have helped train, most of the anaesthetists that treated the victims.

They displayed the virtues of our specialty that I value most: not asking for public recognition or adulation for the work that they do, nor seeking photo opportunities or the reflected glory of others. For them the personal satisfaction of knowing that it was a job well done, calmly, efficiently and courageously. We know that anaesthetists are the backbone of the hospital upon which all other services depend. Solid, unfailable, resourceful, adaptable, selfless; these are the qualities we should treasure and nurture in the next generation.

It was my great privilege to be a small part of the anaesthetic team at Royal Manchester Children’s Hospital. I know every department in my trust performed at the top of their game, indeed so did all of the emergency services across the city, from Greater Manchester Ambulance, faultlessly putting into action its recently rehearsed plan for a mass casualty event at the same venue, to our theatre porters working tirelessly throughout the night. It was a display of teamwork at its finest, even senior hospital managers asking, ‘what can we do to help you?’

In the aftermath of May 2017 many of us have been asked to speak at meetings, locally, nationally and internationally. What everyone wants to know is: what lessons are there to be learnt? What went well and what should we do differently? But all trusts have well researched and practised major incident plans, as well as dedicated and resourceful staff. So I cannot tell you what you should do. No two mass casualty major incidents are the same, and luckily very few involve large numbers of children. Nevertheless, I can pass on some lessons that we learnt.

It is important to manage your resources well. The majority of our workload occurred on the following day and for the rest of the week and into the weekend. Do not call everyone in immediately, as you will have no one fresh to work the next day. To this end I am slightly cautious of WhatsApp major incident groups.

The hospital still needs to function for other patients – we had two medical emergencies that night unrelated to the blast. Consultant anaesthetists are particularly useful in these situations when medical consultants are trying to cope without their juniors!

A continuous ward round of all casualties not receiving definitive care was conducted that night and the following day; this was a new and novel concept. New injuries came to light and investigations were reviewed. Checks were made that antibiotics, vaccinations and pain relief had been prescribed and given and a preoperative assessment for anaesthesia and consent obtained. In our case this ward round was multidisciplinary, led by a consultant anaesthetist.

When both children and their parents have been injured at the same time, parents will often be reluctant to leave their child in order to seek treatment for themselves. A flexible approach is needed to looking after both in the same place.

Not all medical specialties are used to being called in the middle of the night despite running on-call rotas. Getting them to attend can be a challenge in itself but it’s not worth wasting time on. Delegate that task!

As the dust begins to settle, some of our caring must be reserved to help our colleagues and ourselves. Do not underestimate the impact that being involved in these incidents can have on you, not just on those around you. Debriefing is useful for everyone, and remember it should not be the sole preserve of clinical staff.

Finally, as the hospital begins to function normally again, there will be opportunities for the public to show yet again its appreciation for the work done by NHS staff. Gala dinners, local and even national awards follow in quick succession. These awards are not given to individuals but to teams, after all it is teamwork that saved the day! I was lucky enough to be asked to represent my trust at the ‘Pride of Britain’ awards in October and the following day at 10 Downing Street. How does that sit with what I said earlier about the virtues of our specialty? Quite well really, with what I said earlier about the virtues of our specialty! Quite well really, there may not be an ‘I’ in teamwork but there certainly is an ‘A’ – for Anaesthesia, I would suggest.
reduce the 17-years timescale which is

The Accelerated Access Review seeks to


to the NHS has been embraced by the

of innovation to the UK economy and

Crucially, the recognition of the benefit

overcoming the difficulties experienced in developing, commercialising, and

implementation and to learn from and uncover the considerable barriers that still exist. A

innovations in a financially sustainable way.

particularly implementing innovations in a financially sustainable way.

innovation in anaesthesia

Dr Maryanne Mariyaseelvam
Clinical Research Fellow,
Cambridge and NHS Clinical
Entrepreneur Programme Fellow

Dr Peter Young
Consultant in Anaesthesia and
Critical Care, King’s Lynn and RCoA
representative for the NHS Clinical
Entrepreneur Programme

The College has recently pledged its support and sponsorship for the NHS
Clinical Entrepreneur Programme. It is encouraging that anaesthetists are
proportionately represented in a programme that recognises and celebrates
the innovative aspirations of clinicians, and provides support to them in
overcoming the difficulties experienced in developing, commercialising, and
(particularly) implementing innovations in a financially sustainable way.

Crucially, the recognition of the benefit of innovation to the UK economy and
to the NHS has been embraced by the Department of Health and NHS England. The Accelerated Access Review seeks to reduce the 17-years timescale which is

commonly cited as currently needed to scale-up from innovation to widespread adoption in the NHS. Many potential medical advances and innovations from the grassroots paradigm in what is known as ‘the valley of death’, whereby, due to

slow adoption, clinicians lucky enough to find initial investment for an innovation cannot achieve financial sustainability in a timescale required for it to survive. The laryngeal mask airway was initially met by considerable resistance at all levels,

with poor uptake and clinical use, and its considerable benefits could have been lost in its infancy without support from an inspirational entrepreneur, from established specialty leaders, and from the rank and file of our profession. The NHS Innovation hubs now support individuals in the development of their ideas, the Academic Health Science Networks (AHSN) and the NHS Innovation Accelerator (NIA) programme have been launched to support the implementation of emerging and competitively selected innovations, and to learn from and uncover the considerable barriers that still exist. A fledgling grassroots clinical innovation, normally unsupported by multinational companies, needs all the help it can get at the early stages of implementation to survive. Frequently, the multinational giants that have the infrastructure to implement innovations in the NHS, and that have multifaceted influence with professional societies and clinicians, will only adopt grassroots innovations into their portfolio when they see them emerge from smaller businesses in a commercially sustainable way. Beside clinical innovation requires managed risk and a culture of encouragement. Risk averseness and ‘over-management’ rapidly stifle out and kill innovation in its infancy. Regarding implementation, there will always be a desire for more evidence. Frontline clinicians and hospital administrators have their part to play by allowing an innovation to survive through this pathway. They can help by being open to the implementation of new innovations – something that is necessary to allow the gathering of sufficient evidence to bring further support for the innovations.

Our group, the Kings Lynn Institute of Patient Safety (KLIPSuk,
www.klipsuk.com), has produced 12 ‘patent families’ of innovations spread
along the innovation and implementation pathway from the prototype stage,

through to CE and Food and Drug Administration (FDA) approval, to

successfully marketed. To give some examples: the PneuX Pneumonia
Prevention System prevents pulmonary aspiration and lung soiling – the greatest cause of nosocomial mortality in intensive care; the non-injectable
arterial connector (NIC) prevents arterial mis-injection and improves
infection control; and the WeSafe prevents the commonest ‘never event’
in emergency medicine – guidewire retention when placing central venous catheters or chest drains. These three innovations have been selected for
facilitated implementation on the NIA programme, and the former two are
being provided free to end-user trusts through the Innovation Technology
Tariff, giving hospitals the opportunity to try new innovations in a risk-free
way at zero cost. The GlucaSave prevents hypoglycaemia ‘never events’
associated with arterial sampling. The Oxy-Blade is an improvement on
transnasal humidification respiratory insufflation and ventilatory exchange (THRIVE), allowing convenient and cheap apnoeic oxygenation during
direct laryngoscopy without the need for additional training. The DrGUARDian
protects clinicians when accessing controlled and high-risk drugs in the
clinical environment, whilst not impacting on their immediate availability.

When approached with innovations from clinical entrepreneurs, please bear in mind that their journey has been arduous and that their imaginative ideas (which may not align completely with your own prior views, are born out of a simple desire to improve the system for clinicians and patients. To play your part in supporting
innovation in the NHS, when you see a UK innovation support it by facilitating
early implementation in your hospital – and join the innovation revolution.

Conflict of interest
The Queen Elizabeth Hospital NHS Trust, members of KLIPSuk including
the authors and Health Enterprise East are proud to variably share in
ownership of the intellectual property of these innovations.

Further reading
Helpful websites for readers and potential innovators:
NHS Innovation Accelerator (NIA) Programme
www.england.nhs.uk/ourwork/innovation/nia/
Clinical Entrepreneur Programme
www.innovation.england.nhs.uk/en/clinical-entrepreneurship
Innovation and Technology Tariff
www.england.nhs.uk/ourwork/innovation/nia/tariff/
Dr Nicholas Levy, Dr Patricia Mills and Dr Nigel Penfold
Consultant Anaesthetists, West Suffolk Hospital, Bury St Edmunds

This is the second of two articles that the Bulletin has commissioned to highlight the US prescribed-opioid epidemic and the implications for UK anaesthetists.

In the first article we discussed the multifactorial causes of the US prescribed-opioid epidemic. We demonstrated that many, but not all, of these predisposing factors are present in the UK. The UK is also experiencing a problem with prescribed-opioid dependency, although not on the same scale. It may be argued that the surge in prescribed-opioid use in the UK is a consequence of the increasing number of patients with chronic pain. In the US it has been reported that as many as 1 in every 16 previously opioid naïve surgical patients will develop postoperative opioid dependency, and inevitably this must also occur in the UK.

This article will discuss the current response in the UK, and explore some other options available to mitigate this healthcare catastrophe.

The current UK response

Public Health England has funded the Opioids Aware resource, which is promoted by the Faculty of Pain Medicine. Its purpose is to provide support to both patients and prescribers in making fully informed decisions about the use of opioids. It provides information on good practice in prescribing, improving patient safety, and minimising harm from opioids.

The Department of Transport has responded to the increase in prescribed-opioid use by expanding the criteria for ‘drug-driving’ to include prescribed opioids.

A further initiative is the Opioid Pankiller Dependency Alliance (a collaboration including pain and addiction specialists), established in 2017 to advise an All-Party Parliamentary Group on strategies to mitigate the harm from prescribed opioids.

The concept of deprescribing is slowly being accepted by the medical profession, and National Institute for Health and Care Excellence (NICE) now regards deprescribing as an integral component of medicine optimisation. Deprescribing requires recognition that drugs should only be prescribed as a course, and that ongoing prescriptions should be regularly reviewed and all unnecessary drugs stopped in order to reduce adverse drug reactions.

The British National Formulary (BNF) currently states that opioid dependency ‘is rarely a problem with therapeutic use’. This statement is based on flawed science, and the BNF should be updated to reflect current knowledge.

The mandatory elements of the General Medical Council’s postgraduate medical curricula should highlight the risk of prescribed-opioid addiction and emphasise the requirement for deprescribing. This would follow the US trend for improving the education of opioid prescribers.

The UK is at risk of a prescribed-opioid epidemic. As anaesthetists, pain doctors, perioperative medicine physicians, investigators, educationalists, lobbyists and policy-setters, we are ideally placed to avert this impending catastrophe.

Further reading


The US prescribed-opioid epidemic: lessons for perioperative medicine in the UK

(continued)

Part two

Anaesthetic practitioners have a responsibility to ensure that when opioid medication is prescribed there is a deprescribing plan

What else can be done in the UK?

In response to the opioid crisis, the US health regulatory body (the Joint Commission) published Pain assessment and management standards for hospitals. This report requires US hospitals to implement 19 standards encompassing all aspects of service delivery in pain management. The majority of these standards will also require implementation in the UK.

The UK must re-evaluate its reliance on the exclusive use of unidimensional pain-intensity scores, and must support research into multidimensional pain scores.

Anaesthetic practitioners have a responsibility to ensure that when opioid medication is prescribed there is a deprescribing plan. If the patient is admitted on opioids for a pain-relieving operation, we must consider how they will be weaned off these medications until they are eventually stopped. A deprescribing plan should form part of ‘discharge counselling’. Patients should receive written and verbal advice that is specific to them and their surgical procedure. Procedures must also be adapted to prevent repeat prescriptions of postoperative opioids in primary care.

To reduce the potential for opioid diversion the process in which prescribed opioids are used (shortly by someone else), there need to be safeguards within the community to ensure safe disposal of expired or unwanted opioids. The current NICE guideline, Controlled drugs: safe use and management, is limited in its scope to hospital practice, and this needs to be rectified.

Some enhanced recovery programmes use oxycodone as a first-line opioid, as its lack of unpleasant side effects may facilitate earlier discharge. However, this lack of unpleasant side effects contributes to its addictive potential. Consequently oxycodone should be a second-line opioid, in line with Care Quality Commission (CQC) guidance.

Expectations surrounding acute pain management need to be altered. International proponents of enhanced recovery programmes realise this, and are promoting PROCedure-SPECific postoperative pain management (PROSPECT) in order to promote mobilisation and limit opioid use.

Compound analgesics have limited clinical benefits and hinder deprescribing. Their use should be avoided, and there is no rationale for hospitals to stock them.

There is a proposal for patients on opioids to have a yearly review to facilitate deprescribing and rationalisation of their medication. NICE or CQC guidance may be required to mandate this.

In response to the opioid crisis, the US health regulatory body (the Joint Commission) published Pain assessment and management standards for hospitals. This report requires US hospitals to implement 19 standards encompassing all aspects of service delivery in pain management. The majority of these standards will also require implementation in the UK.

The UK must re-evaluate its reliance on the exclusive use of unidimensional pain-intensity scores, and must support research into multidimensional pain scores.

Anaesthetic practitioners have a responsibility to ensure that when opioid medication is prescribed there is a deprescribing plan. If the patient is admitted on opioids for a pain-relieving operation, we must consider how they will be weaned off these medications until they are eventually stopped. A deprescribing plan should form part of ‘discharge counselling’. Patients should receive written and verbal advice that is specific to them and their surgical procedure. Procedures must also be adapted to prevent repeat prescriptions of postoperative opioids in primary care.

To reduce the potential for opioid diversion the process in which prescribed opioids are used (shortly by someone else), there need to be safeguards within the community to ensure safe disposal of expired or unwanted opioids. The current NICE guideline, Controlled drugs: safe use and management, is limited in its scope to hospital practice, and this needs to be rectified.

Some enhanced recovery programmes use oxycodone as a first-line opioid, as its lack of unpleasant side effects may facilitate earlier discharge. However, this lack of unpleasant side effects contributes to its addictive potential. Consequently oxycodone should be a second-line opioid, in line with Care Quality Commission (CQC) guidance.

Expectations surrounding acute pain management need to be altered. International proponents of enhanced recovery programmes realise this, and are promoting PROCedure-SPECific postoperative pain management (PROSPECT) in order to promote mobilisation and limit opioid use.

Compound analgesics have limited clinical benefits and hinder deprescribing. Their use should be avoided, and there is no rationale for hospitals to stock them.

There is a proposal for patients on opioids to have a yearly review to facilitate deprescribing and rationalisation of their medication. NICE or CQC guidance may be required to mandate this.

In response to the opioid crisis, the US health regulatory body (the Joint Commission) published Pain assessment and management standards for hospitals. This report requires US hospitals to implement 19 standards encompassing all aspects of service delivery in pain management. The majority of these standards will also require implementation in the UK.

The UK must re-evaluate its reliance on the exclusive use of unidimensional pain-intensity scores, and must support research into multidimensional pain scores.

Anaesthetic practitioners have a responsibility to ensure that when opioid medication is prescribed there is a deprescribing plan. If the patient is admitted on opioids for a pain-relieving operation, we must consider how they will be weaned off these medications until they are eventually stopped. A deprescribing plan should form part of ‘discharge counselling’. Patients should receive written and verbal advice that is specific to them and their surgical procedure. Procedures must also be adapted to prevent repeat prescriptions of postoperative opioids in primary care.

To reduce the potential for opioid diversion the process in which prescribed opioids are used (shortly by someone else), there need to be safeguards within the community to ensure safe disposal of expired or unwanted opioids. The current NICE guideline, Controlled drugs: safe use and management, is limited in its scope to hospital practice, and this needs to be rectified.

Some enhanced recovery programmes use oxycodone as a first-line opioid, as its lack of unpleasant side effects may facilitate earlier discharge. However, this lack of unpleasant side effects contributes to its addictive potential. Consequently oxycodone should be a second-line opioid, in line with Care Quality Commission (CQC) guidance.

Expectations surrounding acute pain management need to be altered. International proponents of enhanced recovery programmes realise this, and are promoting PROCedure-SPECific postoperative pain management (PROSPECT) in order to promote mobilisation and limit opioid use.

Compound analgesics have limited clinical benefits and hinder deprescribing. Their use should be avoided, and there is no rationale for hospitals to stock them.

There is a proposal for patients on opioids to have a yearly review to facilitate deprescribing and rationalisation of their medication. NICE or CQC guidance may be required to mandate this.
RCOAJ PATIENT INFORMATION RESOURCES

Helping you meet the challenges of informing patients

Part one

Giving patients accurate information regarding the options and risks of anaesthesia is at the core of what we do as anaesthetists, but this has become ever more important for us all following the recent Montgomery ruling.

Generic information contained in patient information resources lays the foundations for patients to take in the specific options and risks that apply to them as individuals. One of the challenges is that patients have a wide range of reading and comprehension abilities. This can make it difficult for us to convey what risk is and, most importantly, how to put that risk into context. Ideally, patients will discuss their specific options and risks when they meet the anaesthetist in the pre-assessment clinic, but often, and less ideally, this will happen in the limited time available on the day of surgery.

Ideally, patients may be too much or too little for one another, so it’s good to have a range of resources and different formats available.

The Patient Information Group at the Royal College of Anaesthetists was set up in 2016 to ‘review and improve the information available to public and the patients’ as stated in the Strategic Plan for 2016–2021. The Patient Information Group (or ‘PIG’, as we call it affectionately) is now reviewing the range of resources produced, and considering how patients can access this information at an earlier stage. We also want to ensure that those involved in pre-assessment know the extent of information on offer from the RCoA, as well as other reliable sources. As a College, we need to support the work of members in pre-assessment services and advertise our patient information resources to hospitals.

What RCoA resources are available for patients?

RCOAJ resources are broadly grouped into four main areas:

Online resources

We have recently updated the website content to include a wide range of FAQs for patients and carers, questions to ask the anaesthetist, a glossary of anaesthetic and medical terms used in our publications, and additional external resources thought to be suitable and useful. Do visit our website and find out what is now available for your patients (www.rcoa.ac.uk/patients-and-relatives).

General information on anaesthesia

The main leaflet in this series, You and Your Anaesthetic, is a good introduction to anaesthesia, covering the basics and designed for easy printing (http://bit.ly/RCoA-YAYA). There is also a more detailed overview of anaesthesia called Anaesthesia Explained. This is well illustrated with coloured photographs and more detailed information covering most aspects of anaesthesia from pre-assessment to postoperative pain relief, and also includes a brief overview of regional anaesthesia and complications (http://bit.ly/RCoA-AR). At 45 pages, it may not be practical to print, but it is ideal for signposting to patients who are computer literate and want to find out more about anaesthesia.

The Risk series

This is a series of 15 leaflets describing the most common and most serious risks patients face from anaesthesia, ranging from sickness and sore throat to anaphylaxis and death or brain damage. The aim of these is to explain to patients the nature of the risk, the measures we take to reduce these complications, and the level of risk from our most recent evidence (http://bit.ly/RCoA-Risk).

Anaesthesia Information series

The Anaesthesia Information series (http://bit.ly/RCoA-AI) provides resources for the most common types of anaesthesia, from spinals and epidurals to local anaesthetics for eye surgery. There are also paediatric resources aimed at children and young people, written in collaboration with the Association of Paediatric Anaesthetists of Great Britain and Ireland (www.rcoa.ac.uk/childrensinfo).

RCoA resources are designed to help patients understand what an anaesthetic is, and the journey from pre-assessment clinic, to arrival in hospital, to discharge. The ‘right’ amount of information given early in their journey can often help allay their anxiety. In the recent SNAP-1 survey (http://bit.ly/24jBlGd), anxiety was frequently reported as being the worst element of having an operation. However, what is the right amount of detail for one patient may be too much or too little for another, so it’s good to have a range of resources and different formats available.

The ‘right’ amount of information given early in their journey can often help allay their anxiety. The Royal College of Anaesthetists is set up in 2016 to review and improve the information available to public and the patients’ as stated in the Strategic Plan for 2016–2021. The Patient Information Group (or ‘PIG’, as we call it affectionately) is now reviewing the range of resources produced, and considering how patients can access this information at an earlier stage. We also want to ensure that those involved in pre-assessment know the extent of information on offer from the RCoA, as well as other reliable sources. As a College, we need to support the work of members in pre-assessment services and advertise our patient information resources to hospitals.

What RCoA resources are available for patients?

RCOAJ resources are broadly grouped into four main areas:

Online resources

We have recently updated the website content to include a wide range of FAQs for patients and carers, questions to ask the anaesthetist, a glossary of anaesthetic and medical terms used in our publications, and additional external resources thought to be suitable and useful. Do visit our website and find out what is now available for your patients (www.rcoa.ac.uk/patients-and-relatives).

General information on anaesthesia

The main leaflet in this series, You and Your Anaesthetic, is a good introduction to anaesthesia, covering the basics and designed for easy printing (http://bit.ly/RCoA-YAYA). There is also a more detailed overview of anaesthesia called Anaesthesia Explained. This is well illustrated with coloured photographs and more detailed information covering most aspects of anaesthesia from pre-assessment to postoperative pain relief, and also includes a brief overview of regional anaesthesia and complications (http://bit.ly/RCoA-AR). At 45 pages, it may not be practical to print, but it is ideal for signposting to patients who are computer literate and want to find out more about anaesthesia.

The Risk series

This is a series of 15 leaflets describing the most common and most serious risks patients face from anaesthesia, ranging from sickness and sore throat to anaphylaxis and death or brain damage. The aim of these is to explain to patients the nature of the risk, the measures we take to reduce these complications, and the level of risk from our most recent evidence (http://bit.ly/RCoA-Risk).

Anaesthesia Information series

The Anaesthesia Information series (http://bit.ly/RCoA-AI) provides resources for the most common types of anaesthesia, from spinals and epidurals to local anaesthetics for eye surgery. There are also paediatric resources aimed at children and young people, written in collaboration with the Association of Paediatric Anaesthetists of Great Britain and Ireland (www.rcoa.ac.uk/childrensinfo).

Dr Hilary Swales
RCOAJ Lead for Patient Information, and Chair, Patient Information Group

Elena Fabbrani
RCOAJ Policy and Patient Information Co-ordinator
REFORMING COLLEGE GOVERNANCE

January 2018’s Bulletin (page 13) reported on the College’s review of its governance and structures. This work is nearing its completion, and more details can now be shared about the proposed changes.

All charities have a set of rules to govern how they work; for the College this is our Charter and Ordinances. In our 25-year history they have been amended, but there has never been a major review – until now. As well as tidying up the Charter and Ordinances to reflect the modern College and current medical practice, RCoA’s Council have considered a number of amendments aimed at ensuring the smoother running of the organisation. The major proposed changes include:

- setting up a board of trustees. With RCoA now having a turnover of over £12 million, investments of a similar value, and employing 100 staff we think it is time to establish a board of trustees who, working alongside Council, will continue to oversee professional issues. With a minimum of two-thirds of its members being elected Council members, and the remaining members (trustees appointed Council), the board of trustees should ensure that the RCoA continues to run effectively. It is envisaged that the board of trustees will meet four times each year and primarily discuss issues relating to the RCoA as a business, as an employer and as owner of 35 and 34 Red Lion Square
- formally establishing the new student and foundation membership categories, launched in November last year

The above changes will require the approval of the members and fellows, and will therefore be discussed at this year’s Annual General Meeting on 22 May (see below).

If you have any questions about any of these changes or any other aspects of RCoA’s governance, please contact Tom Grinyer, RCoA’s Chief Executive Officer ceo@rcoa.ac.uk

2018 ANNUAL GENERAL MEETING

The 2018 Annual General Meeting of the Royal College of Anaesthetists will be held as follows:

Tuesday 22 May 2018 at 12.50pm
British Museum, Great Russell Street, London WC1B 3DG

All members and fellows are welcome to attend. A full AGM agenda will be available online the month before the meeting.

The procedure for the submission of motions to the agenda is set by RCoA’s Regulations. Any motions for the meeting should be submitted to the Chief Executive by 9 April 2018 to: ceo@rcoa.ac.uk for consideration at the following Council meeting.

This AGM takes place as part of Anaesthesia 2018: The International Meeting of the RCoA. Visit www.rcoa.ac.uk/anaesthesia to learn more.
ELECTION TO COUNCIL 2018
Meet the new members of Council

Voting for election to Council of the Royal College of Anaesthetists closed on Monday 4 December at 5:00pm. The College can confirm the following candidates have been elected:

Consultant vacancies
Dr Claire Mallinson
Dr Sarah Ramsay
Dr Helgi Johannsson
Dr Claire Shannon
Dr Mark Forrest

Trainee vacancy
Dr Jamie Strachan

As in previous years the ballot process was independent and managed by Electoral Reform Services (ERS). Terms of office commence later this month.

The full results can be viewed here: http://bit.ly/2BTXYsN

Dr Liam Brennan, President of the RCoA said:

I would like to thank all 22 candidates for standing. I am delighted to see a record number of candidates and a good turnout.

‘Congratulations to all those who were elected to Council and I look forward to working with them. I would also like to thank all those who were not successful this year. I am pleased those voting had such a diverse and experienced field of candidates to choose from.

‘I am pleased to see this level of participation in our elections as we embark on our next 25 years as a Royal College. Once again, this is a sign of an engaged fellowship and together we can face the challenges ahead with a strong, united professional voice.’

Dr Claire Mallinson
After completing anaesthetic training in the North Thames rotation, I was appointed as a consultant anaesthetist specialising in anaesthesia for children’s complex deformity surgery. I am also director of medical education (deputy medical director) at Guys and St Thomas Hospital NHS Trust London.

I am immediate past chair of the National Association of Clinical Tutors (NACT), in which I contributed to various national reports and helping to start DEMEC [Developing Excellence in Medical Education Conference]. I continue to participate in national dialogue for medical education.

I am an active participant of Health Education England South London, often speaking and contributing to programmes. As chair of NACT, I have also contributed to various national reports including The Temple Report in 2010.

Dr Sarah Ramsay
I qualified from St Mary’s in 1991 and trained in anaesthesia and intensive care in London. I worked in Hong Kong as an Associate Professor at the Chinese University of Hong Kong before finally returning to my roots in Glasgow as a consultant at the Western Infirmary. In 2015 three hospitals merged to become the Queen Elizabeth University Hospital, Scotland’s largest. I am currently the FRCA tutor and the Scottish Intensive Care Society Audit Group audit lead for our large combined critical care floor.

I was the honorary secretary of the Scottish Intensive Care Society for four years and in 2015 I was elected to the RCoA Scottish Board, becoming first the secretary and then the chair late in 2017.

Dr Helgi Johannsson
I have been a consultant anaesthetist at Imperial College Healthcare since 2007, having trained at St Bartholomew’s, then in North and East London.

My clinical work is based at St Mary’s hospital and includes a wide variety of disciplines, including trauma care, oesophagogastric surgery, obstetrics and bariatrics. My other interests include education, social media and medicine, and music and exercise.

Dr Claire Shannon
Following a senior registrar rotation at the Middlesex Hospital and fellowships in paediatric anaesthesia, I was appointed as consultant anaesthetist with paediatric interest at Guys and St Thomas’ Hospital in 1997.

My clinical interests are paediatric cardiac anaesthesia and adult and paediatric ENT and difficult airway management.

I have been College tutor, training programme director and regional advisor for the South East region.

I was lead regional advisor from 2014–2015, head of the specialty school for anaesthesia and intensive care medicine from 2015 to date, and co chair of the London Specialty Advisory Board.

I am an examiner for the Final FRCA examination.

Dr Mark Forrest
After graduating in 1990, I completed my anaesthesia training on the North West Thames Rotation, including time at the Hammersmith Hospital, Harfield and The Royal Brompton. I returned home to Manchester when I was appointed as a consultant anaesthetist at the Royal Infirmary in 1998. My clinical interests are cardiac anaesthesia and intensive care, whilst latterly I have also developed an interest in bariatric anaesthesia.

I have been involved in education pretty much since my appointment, both within and outside anaesthesia. I am currently director of medical education at the Manchester University Foundation Trust.

I have a particular interest in using analysis of the GMC trainee survey to inform quality improvement in training, and also occasionally lecture on trainees and social media. I have been a Primary examiner for ten years, heading the pharmacology group and being vice chair for the last year.

Dr Jamie Strachan
After medical school and foundation training in Newcastle Upon Tyne, I spent a year working in emergency medicine in New Zealand before moving to Oxford and training in anaesthesia.

In 2013 I began dual training in intensive care medicine. My interests are adult intensive care, and technology and its application to healthcare, and education. I started a two-year out of programme experience at the College in 2016 working as the Technology Strategy Programme Fellow, before standing for the Council post.
PERIOPERATIVE JOURNAL WATCH

Dr Katie Samuel, Dr Laura McLoughlin, Dr Douglas Blackwood and Dr Deborah Douglas
Perioperative Medicine Fellows, University College London Hospitals

Early mobilisation programme improves functional capacity after major abdominal cancer surgery: a randomized controlled trial
This Brazilian research group conducted a single-blinded randomised, controlled trial in patients who underwent major abdominal cancer surgery. It looked at whether an early mobilisation programme (involving supervised aerobic exercise, resistance and flexibility training) enabled patients to walk three metres unaided at day five post surgery compared to standard rehabilitation. 1108 patients were recruited with only nine (6.7 percent) patients in the intervention group unable to walk three metres at day five compared to 21 (38.9 percent) patients receiving standard care (P=0.01), producing a number needed to treat of five (95 percent CI:1.3–17). A postoperative exercise programme based on supervised exercise was therefore found to be safe and feasible, and to improve functional outcome in this patient cohort.


Postoperative delirium in elderly patients is associated with subsequent cognitive impairment
With an ageing population, postoperative delirium (POD) is a common occurrence. This study examined patients who underwent anaesthesia enrolled in the Mayo Clinic Study of Aging (a population-based longitudinal study) to determine whether POD heralded subsequent cognitive decline. 2014 patients who underwent anaesthesia for surgery were included, with a mean age of 81. Of these, 74 (3.7 percent) developed POD. POD was more common with increasing age, pre-existing cognitive impairment, fewer years of education, males, and orthopaedic, thoracic, and cardiovascular surgery. On follow-up assessment, the frequency of mild cognitive impairment or dementia was higher in patients with POD compared with those without (33.3 vs 9.0 percent; adjusted OR, 3.00 (95 percent CI, 1.12–8.03); P=0.029).

Mild cognitive impairment or dementia is therefore a risk for POD, and elderly patients who experience POD are more likely to be diagnosed subsequently.


Incidence of myocardial infarction after high-risk vascular operations in adults
This retrospective cohort study used the well-studied American College of Surgeons National Surgical Quality Improvement Programme (NSQIP) data to analyse the primary outcome of postoperative myocardial infarction (POMI) in over 90,000 patients undergoing a high-risk vascular procedure. Emergency and elective operations were included, with the aim of identifying whether presumed improvements in perioperative care made an impact. Those patients undergoing open aortic procedures had a POMI incidence of 2.7 percent in 2009 and 3.1 percent in 2014, with therefore no evidence of temporal decline. Those undergoing the less invasive infragenual arterial bypass had a significantly lower POMI rate of 1.9 percent, and POMI rates didn’t decrease despite presumed improvements in perioperative care, and invasive procedures carry a higher risk compared to less invasive procedures.


Sirs,

What a sad and discouraging article by Dr Krish Ramachandran. Between a rock and a hard [work]place [Bulletin 2017;106:40–41]. Tongue in cheek I hope.

Retirement does not have to beek out in Tloneliness, boredom and poverty. I had to take early retirement 19 years ago when I was 56 because I had developed rheumatoid arthritis (RA). I was initially devastated, as medicine in general and anaesthesia in particular, had been my life. But I quickly realised that if the RA could be well managed, all sorts of opportunities would open up. So I began researching the answer to what was a pressing question, “What will make this enforced retirement a really good time?” The evidence is that there are six things necessary for a productive and contented retirement.

1 Keep physically active. The health benefits in older age are huge; it is the one thing which reduces the risk of dementia; it is essential in the management of chronic disease; you visit the doctor less often than those who are sedentary, and when you do get sick you recover more rapidly. The American College of Sports Medicine Activity Guidelines is a good place to find out what and how much activity we need to do.

2 Have a routine. Until retirement, life has some sort of pattern and order to it which suddenly disappears when you stop work. Establishing new patterns and routines prevents drift and aimlessness.

3 Take up some form of voluntary work. You feel as if you are making a contribution to the community, it helps you to look outward and builds up a new circle of friends.

4 Learn something new; a language, a musical instrument, and new skill. It is stimulating and generates a sense of achievement.

5 Nurture friendships with younger people, be willing to learn from them and embrace new ideas. Absolutely refuse to go down the Victor Meldrew route of grumpy discontent and criticism. We need to value and nurture the social circle of our own age group so long as libraries of ill health are banned.

6 Plan holidays. It is surprising how much activity we need to do, so in time: Plan holiday at least a year works well.

Finally, lets be honest, retired doctors are not poor.

Dr John Searle OBE, Retired Consultant Anaesthetist, Exeter
NEW TO THE COLLEGE

At a meeting of Council held on Wednesday 13 December 2017, the following appointments/re-appointments were approved (re-appointments marked with an asterisk).

Regional Advisors
Anaesthesia
Northern Ireland
Dr R Laird (Altnagelvin Area Hospital, Londonderry) in succession to Dr D Lowry

Deputy Regional Advisors
Anaesthesia
West of Scotland
Dr P Harrison (Queen Elizabeth University Hospital, Glasgow) in succession to Dr G Hindrich

College Tutors
London
Dr A E Richards (Horton General Hospital) in succession to Dr J Hewitt-Gray

South East London
Dr K R Srinivas (Lewisham Hospitals) in succession to Dr C Townley

North Central London
*Dr P Harris (Harefield Hospital)

Thames Valley
Oxford
Dr L Lee (Wycombe Hospital) in succession to Dr M Size

Wessex
Dr J Anns (Royal Hampshire County Hospital) in succession to Dr S Townley

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

East Midlands
Dr Maria Armstrong
West Midlands
Dr Neil Britton
Dr Chetana Kataria
North West
Dr Chee-Fone Chu
Dr Vaishali Adiga
South East
Dr Vishal Dhokia
North Central London
Dr Ravindra Mallavalli
Yorkshire & The Humber
Dr Tenea Saska

The following list of Fellows by Examination from December 2017 were received and approved by Council in January.

Abayasirihe Damunu
Adrian Abubakr
Agombar David Edward
Alkhtair Nafeesa
Al-Hamas Mohammad Fayaz Hammod
Ali Amr Mohammad Talaat Abdelaziz
Allidis Jennifer Charlotte
Allirajah Suhanyu
Archer Charles Stephen Radford
Ardelean Ema Nicolita
Arora Kapil Dev
Ashie Marion Frances
Baluch Safi Nazir
Bapat Anuradha
Barnes Louise
Baxter Gregg James
Baynham Matthew Jonathan Michael
Beck Andrew Scott
Bland Joanne Rebecca
Blethyn Kate
Bolton Emily Josephine
Bolton Peter James Robert
Borkert Jones Caroline
Borthakur Bipidu
Bowes Leonora Katrina
Broder Elizabeth Abigail
Buchanan Eila
Burnham Richard Paul
Butxton William Paul
Campbell Stuart Alexander
Carroll Graeme Craig
Chan Chun Lam Charles
Cheng Yee Yin
Chong Martin Shao Faong
Choudhury Sada
Christo Christopher
Clayton Matthew Andrew
Clow Christopher
Cockroft Melanie Louise
Colhoun Rory Jefferson
Colquhoun Frances
Cooke Katie Louise
Costello Alice Margaret
Cranfield Alastair
Cronley Trina Karen
Cunningham Katie Elizabeth
D’Silva Stuart George
Dallimore Clare Margaret
Dalton Julian
Dauod Ahmad Munaf
Das Dwijanjan
Dasari Kavikumar
Davies Charlotte Elizabeth
De Vries Talitha Mirja
Dean Jonathan Martin Edward
Deane Crawford
Denniss Hermione Horriet
Dhanik Haripand
Dondapati Srinivas Suri Kumar
Edie Susanne
Edmondsdon Emily Harriet Louise
Edwards Sean William
El Sheikh Saheen Helen
Elhamadawy Hazem Ezat Ahmed
Elbanna Reem Esmat Mohammed
Elrefaey Ahmed Abdelrahman Ahmed
Escott Gareth Richard
Evans Hywel Tudur
Eveliegh Mark Oliver
Farah Sheenoud Malak Gurguis
Faulkner Nikkii Elizabeth
Fitzsimmons Kathryn Marie
Freeman Neoma Elizabeth
Frein von Sass Christine
Friel Clare Theresa
Fry Rebecca Louise
Fung Ming
Funnell Samuel Alexander
Gadre Amit Vivas
Gardener Michelle Lisa
Ghurma Yusuf
Gibson Rebecca Sarah Jayne
Gillani Ahmed Ali
Gilley John David
Greeneway Timothy Harold
Guha Snehasish
Hackney Joanna Clare
Hall Alexander James
Hall Andrew Peter
Hall Tanya Joy
Hammerbeck Henry
Hand Laura Jayne
Harkett Lyndon
Harri Rebecca Angharad Fech Alun
Harrup Andrew
Harrison Hanna
Harshan Divya
Hart Sarah Marie
Hay David Gordon
Hayakawa Heloise Clare
Hilton James
Hirst Joy Hannah
Honstvet Christopher Anders
Hooper James William
Homor Christopher William Martell
Houston Emma Louise
Hughes Sean Cathrin
Hunter Katherine Elizabeth
Hussien Eid Mansy Mohammed
Hutchinson Jenna Victoria
Hyde Eleanor Louise
Iqbal Hassan
Ireland Edward Charles
Jack James Martin
Jain Anshant
Jamil Sadek
Janardhanan Ganapathy Subramani
Jayawardana Baddegama Hewage
Akanksha Mahima
Jayawardhana Priysha Ama
Jeans John Paul Stanton
Jeevananthan Rajeev
Jenkins Matthew John
Kamalanathan Supakini
Kamath Max Storam
Kee Mitchell Antony
Kelly Thomas Patrick
Kerr Michael Dylan
Kestner Samuel Booqhnratn Theodor
Kher Prabhjeet Kaur
Knight Martin James
Knight Georgia
Kuppussamy Elyasvendhlan
Kurup Kumburumathaliya
Lafferty Brian
Lalla Sonia
Lathay Rebecca Kate
Lawley Peter John
Lee Sandy Sin Ting
Leees Hannah Clare
Lennard James Matthew Thomas
Lewin Owen John
Liyanagunawardana Dhanshika
Rangana
Luff Delina
Luo Guanni
Majumdar Deepankar Nandy
Makam Kaushik
Manicom Aimee Tarryn
Mankad Nilay
Manou-Stathopoulou Vasiliki
Marasinghe Indrath Marasinghe
Patrnananagale Piyanakara Kumara
Mason Harry Charles
Mcateer Claire Catherine
McClore Catherine Elizabeth Mary
Mcgregor Tobias Edward
McNab Raj Vira
McNamara Kevin Patrick
McNaughton Daniel
Meacher Karen Rebecca
Mehtoora Sauabh
Meneley Stephen James
Miles Edward Timothy Charles
Milton Ross Alexander
Mistry VINEeth Anindikumar
Mohammed Ahmed Sabry Abdelfadeel
Moody Thomas
Moore Gregory Andrew
Moran Noah Tobias
Moran Peter Daniel
Morgan Douglas Robert
Morgan Olivia Toby Charles
Moretter Amanda Leonie
Mourdach Maxene Jane
Murray Christopher
Murray Helen
Mwaara Lucy Wambui
Nagendran Myura
Naji Saqib
Neale Elizabeth Ann
Neall Georgina Louise
Neill Kerry Elizabeth
Neun Maximilian
Ng Fung Koi
Nolan Louise Mary
Nunn Karen Philip
O’Brien Ian David
O’Connor Dominic Charles
Oakley Laura Louise
Oyewole Molola
Peck Emma Suzanne
Pallister Emily Charlotte
Panesar Paul Harvinder
Parker Rebecca Faye
Partidge Alastar Simon
Patel Jashel
Patel Jignesh Khilan Kumar
Patel Reema
Penston Victoria Kathryn
Perera Antony Chamil Manohan
Permall Natasha Nila Devi
Perry Jonathan Geoffrey
Pinder Annie
Pinnamaneni Nagendra
Pishbin Shadi
Pokhrel Savin
Press Christopher Paul
Pyper Paula Claire
Quereshi Ishaq
Raghunathan Arand
Rashid Yassir Azad
Raving Divya
ELECTION TO THE RCoA SCOTTISH BOARD 2018: RESULTS

Voting for the vacancies to the RCoA Board for Scotland closed on 11 January 2018 at 5.00pm. Many thanks to the six candidates who stood for the three consultant vacancies and the four candidates who stood for the trainee vacancy. Elector turnout was 44.2 percent in the consultant election and 34.6 percent in the trainee contest.

I am pleased to announce that the following candidates were elected to the consultant board positions:

- Dr Philip Bolton
- Dr Jonathan McGhie
- Dr Stephen Cole

The full results of the consultant election can be found via the following link: http://bit.ly/2mniPOL

The successful candidate for the trainee board position was:

- Dr Alastair Hurry

The full results of the trainee election can be found via the following link: http://bit.ly/2mKL90C

The ballot process was managed on behalf of the College by Simply Voting. Thanks again to all the candidates who took part.

Tom Grinyer
Chief Executive Officer

AS WE WERE (OR SHOULD BE?)

The Oxford Dictionary of National Biography (ODNB)

Perhaps I shouldn’t tell you about this wonderful resource in case it distracts you and you spend too long browsing it.

There are over 60,000 biographies: the range is extensive and astonishing, including some who are so obscure you wouldn’t recognise their names. Certainly all ‘the Great and the Good’ are there, some so not so good and some thoroughly bad. But how do you find and use it? At no cost it can be accessed via your public library, and most of them subscribe to the ODNB. As a member of your local library, you’ll have a library card with a number.

Now go to www.oxforddnb.com, locate the ‘Find a Person’ link, type in your library card number and password – they’re for people who pay. Go to ‘Sign in with your Library Card’ and click on ‘Login’. hey presto, you’re in.

There are over 60,000 biographies: the range is extensive and astonishing, including some who are so obscure you wouldn’t recognise their names. Certainly all ‘the Great and the Good’ are there, some so not so good and some thoroughly bad. But how do you find and use it? At no cost it can be accessed via your public library, and most of them subscribe to the ODNB. As a member of your local library, you’ll have a library card with a number.

Now go to www.oxforddnb.com, locate the ‘Find a Person’ link, type in your library card number and password – they’re for people who pay. Go to ‘Sign in with your Library Card’ and click on ‘Login’. hey presto, you’re in.

Perhaps I shouldn’t tell you about this wonderful resource in case it distracts you and you spend too long browsing it.

There are over 60,000 biographies: the range is extensive and astonishing, including some who are so obscure you wouldn’t recognise their names. Certainly all ‘the Great and the Good’ are there, some so not so good and some thoroughly bad. But how do you find and use it? At no cost it can be accessed via your public library, and most of them subscribe to the ODNB. As a member of your local library, you’ll have a library card with a number.

Now go to www.oxforddnb.com, locate the ‘Find a Person’ link, type in your library card number and password – they’re for people who pay. Go to ‘Sign in with your Library Card’ and click on ‘Login’. hey presto, you’re in.

Perhaps I shouldn’t tell you about this wonderful resource in case it distracts you and you spend too long browsing it.

There are over 60,000 biographies: the range is extensive and astonishing, including some who are so obscure you wouldn’t recognise their names. Certainly all ‘the Great and the Good’ are there, some so not so good and some thoroughly bad. But how do you find and use it? At no cost it can be accessed via your public library, and most of them subscribe to the ODNB. As a member of your local library, you’ll have a library card with a number.

Now go to www.oxforddnb.com, locate the ‘Find a Person’ link, type in your library card number and password – they’re for people who pay. Go to ‘Sign in with your Library Card’ and click on ‘Login’. hey presto, you’re in.

Perhaps I shouldn’t tell you about this wonderful resource in case it distracts you and you spend too long browsing it.

There are over 60,000 biographies: the range is extensive and astonishing, including some who are so obscure you wouldn’t recognise their names. Certainly all ‘the Great and the Good’ are there, some so not so good and some thoroughly bad. But how do you find and use it? At no cost it can be accessed via your public library, and most of them subscribe to the ODNB. As a member of your local library, you’ll have a library card with a number.

Now go to www.oxforddnb.com, locate the ‘Find a Person’ link, type in your library card number and password – they’re for people who pay. Go to ‘Sign in with your Library Card’ and click on ‘Login’. hey presto, you’re in.

Perhaps I shouldn’t tell you about this wonderful resource in case it distracts you and you spend too long browsing it.

There are over 60,000 biographies: the range is extensive and astonishing, including some who are so obscure you wouldn’t recognise their names. Certainly all ‘the Great and the Good’ are there, some so not so good and some thoroughly bad. But how do you find and use it? At no cost it can be accessed via your public library, and most of them subscribe to the ODNB. As a member of your local library, you’ll have a library card with a number.

Now go to www.oxforddnb.com, locate the ‘Find a Person’ link, type in your library card number and password – they’re for people who pay. Go to ‘Sign in with your Library Card’ and click on ‘Login’. hey presto, you’re in.

Perhaps I shouldn’t tell you about this wonderful resource in case it distracts you and you spend too long browsing it.

There are over 60,000 biographies: the range is extensive and astonishing, including some who are so obscure you wouldn’t recognise their names. Certainly all ‘the Great and the Good’ are there, some so not so good and some thoroughly bad. But how do you find and use it? At no cost it can be accessed via your public library, and most of them subscribe to the ODNB. As a member of your local library, you’ll have a library card with a number.

Now go to www.oxforddnb.com, locate the ‘Find a Person’ link, type in your library card number and password – they’re for people who pay. Go to ‘Sign in with your Library Card’ and click on ‘Login’. hey presto, you’re in.

Perhaps I shouldn’t tell you about this wonderful resource in case it distracts you and you spend too long browsing it.

There are over 60,000 biographies: the range is extensive and astonishing, including some who are so obscure you wouldn’t recognise their names. Certainly all ‘the Great and the Good’ are there, some so not so good and some thoroughly bad. But how do you find and use it? At no cost it can be accessed via your public library, and most of them subscribe to the ODNB. As a member of your local library, you’ll have a library card with a number.

Now go to www.oxforddnb.com, locate the ‘Find a Person’ link, type in your library card number and password – they’re for people who pay. Go to ‘Sign in with your Library Card’ and click on ‘Login’. hey presto, you’re in.
And this is my point. The ODNB doesn’t recognise the outstanding contributions made to anaesthesia, and to medicine generally, by some of our deceased colleagues. Put “Anaesthetist” into the search article title box and you get 12 names including James Robinson, the dentist who handed over to John Snow. Henry Hill Hickman is only found if “Anaesthesia” is put in the box and his is the sole name. Simpson is not included under either.

More suggestions are welcome. But, more importantly, please bombard the ODNB with names of any deceased eminent anaesthetists who you feel should be included. Having logged on, click on ‘Tools and Resources’ at the top of the page. Towards the bottom of that page, click on ‘notes for contributors’ to get the website for contributors which is: www.oxforddnb.com/page/Contributors. However, I don’t find this is helpful if you wish to suggest a new entry. A direct email to info-oxforddnb@oup.com may work. Please do this. I believe passionately in enhancing the status of our specialty by including more anaesthetists in the Dictionary of National Biography.

My personal selection for entries into the ODNB is: Tom Boulton, Derek Wylie, Gordon Jackson Rees, and Alfred Lee. I hope that their virtues are obvious.

For information on the Lives of the Fellows project please visit: www.rcoa.ac.uk/lives-of-the-fellows

CONSULTATIONS

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

<table>
<thead>
<tr>
<th>Originator</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical Council</td>
<td>Updating our expectations of newly qualified doctors in the UK: reviewing the outcomes for graduates*</td>
</tr>
<tr>
<td>Department of Health</td>
<td>Promoting professionalism Reforming regulation*</td>
</tr>
<tr>
<td>Royal College of Nursing</td>
<td>Review of intercollegiate safeguarding children and young people: roles and competences for health care staff 2014 edition</td>
</tr>
<tr>
<td>House of Commons Health Select Committee</td>
<td>Sustainability and transformation Partnerships inquiry*</td>
</tr>
<tr>
<td>NHS England</td>
<td>Supporting research in the NHS*</td>
</tr>
<tr>
<td>The National Institute for Health and Care Excellence</td>
<td>Guideline scope consultation – hip, knee and shoulder joint replacement</td>
</tr>
<tr>
<td>The National Institute for Health and Care Excellence</td>
<td>Decision-making and mental capacity</td>
</tr>
<tr>
<td>Royal College of Surgeons of England</td>
<td>Commission on the future of surgery*</td>
</tr>
</tbody>
</table>

DEATHS

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

Dr June Roberts, Leeds
Dr Robert J Thompson, Dover
Dr John W Warrick, Dorset

Please submit obituaries of no more than 500 words, with a photo if desired, of fellows, members or trainees to: obituaries@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 Ben Clevenger, Royal National Orthopaedic Hospital, Stanmore
Dr Callum Kaye, Aberdeen Royal Infirmary (NHS Grampian)
Dr Umar Ali Ikram, Warwick Hospital

APPOINTMENT OF Members, Associate Members and Associate Fellows

Associate Fellow
Dr Suzanne Sophia Stephan

(Bulletin | Issue 108 | March 2018)

(Left to right): Dr Derek Wylie, Dr Jackson Rees and Dr Tom Boulton
NIAA ANNUAL SCIENTIFIC MEETING 2018

We are pleased to announce that the third National Institute of Academic Anaesthesia (NIAA) Annual Scientific Meeting will take place at the RCoA on Monday 21 May 2018.

This meeting will include updates on NIAA-related research activities including the Health Services Research Centre (HSRC), the UK Perioperative Medicine Clinical Trials Network [UK POM CTN], and as 2018 is the 10 year anniversary of the NIAA there will be a look back at its achievements and a focus on plans for the future. Book your study leave now for an event not to be missed!

<table>
<thead>
<tr>
<th>Standard</th>
<th>Trainee*</th>
<th>Senior fellow*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Price</td>
<td>£45</td>
<td>£35</td>
</tr>
</tbody>
</table>

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

*Delegates must be trainee or senior fellow members of the RCoA to be eligible for the reduced rate.

NIAA RESEARCH AWARD 2018

The Annual Scientific Meeting also includes the NIAA Research Award which is open to all current and active researchers of anaesthesia, critical care, perioperative medicine and pain across the UK. It provides a great opportunity for new investigators to get their work recognised.

Applicants for the award should submit an abstract of their ‘body of work’ based on a clear, evidence-based research question. Short-listed applicants will be invited to present at the meeting and the overall winner will be announced on the day.

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

The deadline for Research Award applications is Monday 12 March 2018.

VACANCY: CHAIR OF THE NATIONAL INSTITUTE OF ACADEMIC ANAESTHESIA BOARD

Applications are currently invited for the role of chair of the National Institute of Academic Anaesthesia (NIAA) Board.

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

The successful candidate will develop and oversee the strategic direction of the NIAA. They will work closely with other senior members of the partnership organisations, as well as with the chair of the NIAA Research Council, Director of the Health Services Research Centre (HSRC), Director of the UK Perioperative Medicine Clinical Trials Network [UK POM CTN], NIAA Grants Officer, NIAA Academic Training Coordinator, and the NIAA administrative team based at the RCoA. They will also lead on maintaining positive and productive relationships between the NIAA and key stakeholders, for example, the National Institute for Health Research (NIHR).

The position is a fixed-term post of three years, renewable for a further three-year period subject to performance. There is no remuneration for the role.

Those who are interested are strongly encouraged to discuss the role with current post holder Professor Monty Mythen, who can be contacted by email info@niaa.org.uk

Further information about the NIAA, the job description and person specification, and how to apply is available on the NIAA website: www.niaa.org.uk

Closing date for applications: Friday 6 April 2018

Interviews will be held in April 2018 (date TBC)

The role will formally commence in July 2018, with a handover throughout May–June 2018.
17th Peri-Operative CPET Course: A POETTS Accredited Course
London, 16th & 17th May 2018
www ebpom.org

EBPOM 2018: Annual London Peri-Operative Medicine Congress
IET Savoy Place, London, 4-6 July 2018
Call for abstracts - Deadline 30th March 2018
POETTS Annual Meeting and TRIPOM Annual Meeting, Friday 6 July 2018
www ebpom.org

20th Dingle Congress: Current Controversies in Anaesthesia and Peri-Operative Medicine
Dingle, County Kerry, Ireland
Monday 8th to Friday 12th October 2018
Call for Abstracts - Deadline 16th July 2018
www ebpom.org

THE MSA SAQ WRITERS CLUB
The Writers Club has seen more than 800 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:
Timed Practice++ in the Mersey Method of Answering SAQs
Free Admission to the SAQ Weekend Courses
Acquisition of a useful Collection of Answer Sheets from Others
Valuable Motivation towards Sustained Revision
Membership Fee: A Single Payment of £400
Members are entitled to all benefits until successful in the SAQ Paper
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 2018</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary SBA/NCQ</td>
<td>19 - 25 July</td>
<td>October 2018</td>
</tr>
<tr>
<td>Primary OSCE Weekend</td>
<td>20 - 22 April</td>
<td>October 2018</td>
</tr>
<tr>
<td>Primary Viva Weekend</td>
<td>27 - 29 April</td>
<td>October 2018</td>
</tr>
<tr>
<td>Primary OSCE/Orals</td>
<td>4 - 11 May</td>
<td>October 2018</td>
</tr>
<tr>
<td>Final Written ‘Booker’</td>
<td>12 - 16 August</td>
<td>February 2019</td>
</tr>
<tr>
<td>Final SBA/NCQ</td>
<td>17 - 23 August</td>
<td>February 2019</td>
</tr>
<tr>
<td>Final SAQ Weekend</td>
<td>24 - 25 August</td>
<td>February 2019</td>
</tr>
<tr>
<td>Final Viva Revision</td>
<td>12 - 17 May</td>
<td>November 2018</td>
</tr>
<tr>
<td>Final Viva Weekend</td>
<td>8 - 10 June</td>
<td>November 2018</td>
</tr>
</tbody>
</table>

*Thank you for what was truly an excellent course last week. I am very pleased to report that I passed both the OSCE and the Viva on my first attempt.
I got a lot out of your course - not only the opportunity to be around colleagues sitting the exam so that we could pool our collective knowledge but also a new perspective on the task of the examiner and a new perspective on professional examinations in general. It is true that I spent a lot of my time on this exam, and occasionally allowed it to get on top of me; to the detriment of my overall well-being and relationships with those nearest to me. Your focus on the real stresses in life helped me to put the exam in perspective, whilst giving it the respect it deserves.
All in all I will be thoroughly recommending the Mersey course to all my colleagues in future, and I will endeavour to be back for the final. Everyone I’ve spoken to who has been before talks about how much they learned and how they appreciate your dedication to teaching the next generation of anaesthetists.*
- Primary OSCE Viva Candidate, November 2017

To see Details of all our Courses please visit: www.msa.org.uk or contact us as: enquiries@msa.org.uk
CPD STUDY DAY
16 March 2018 | The Studio, Birmingham
Join us as we review the most relevant day-to-day anaesthetic issues and explore newly introduced ideas and concepts around improving anaesthetic practice.
Sessions include:
- fracture neck of femur
- robotic and laparoscopic surgery
- outcome benefits of regional anaesthesia
- pain relief for the paediatric patient.

MANAGING MASS CASUALTIES
18 April 2018 | RCoA, London
Join us as we take a closer look at how hospitals in different cities and countries dealt with the aftermath of disasters.
Sessions include:
- Westminster, London Bridge and Grenfell – three major incidents in a short time period
- preparing for a major incident
- lessons from the battlefield
- managing orthopaedic injuries.

REGONAL ANAESTHESIA
19 March 2018 | RCoA, London
Explore the pros and cons of regional anaesthesia and take an in-depth look at the latest research. Is regional anaesthesia always the best option?
Sessions include:
- regional anaesthesia and analgesia for abdominal surgery
- ultrasound and neuroaxial blocks
- catheter techniques
- spinal anaesthesia for day case surgery.

CPD STUDY DAYS
12–13 June 2018 | RCoA, London
This event will cover a broad range of engaging topics bringing you up to speed on the latest thinking and new techniques.
Sessions include:
- perioperative medicine
- transoral robotic head and neck surgery
- managing patients with phobias and extreme anxieties
- severely hypoxic patients.

AAC (Advisory Appointment Committee) Assessors
One of the roles of the College is to nominate assessors to sit on Advisory Appointments Committees (AACs).
This role is regarded as an important part of the maintenance and improvement of standards of practice in anaesthesia.
AAC assessors are asked to volunteer to attend panels throughout the year and there is no limit on the number you can attend. All new assessors must attend a training day at the College and update this training every three years.

How do I get involved?
The RCoA is currently recruiting AAC Assessors for England Wales and Northern Ireland across all specialties.
For more information, please contact aac@rcoa.ac.uk or visit www.rcoa.ac.uk/aac

*Delegates must be trainee or senior fellow members of the RCoA to be eligible for the reduced rate.
AIRWAY EVENTS

Our range of airway events provide learning opportunities in many forms, from hands-on simulation sessions through to group discussions and seminars.

Appropriate for all grades of anaesthetic trainees, specialty doctors and consultants.

Tracheostomy Masterclass
9 March 2018 | RCoA, London

Airway Workshops
Topics include: fibreoptic handling skills, supraglottic airways, front of neck airway, awake fibreoptic intubation, video laryngoscopy, guidelines and human factors.

18 April 2018 | RCoA, London
13 June 2018 | RCoA, London

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

PATIENT SAFETY EVENTS

Our patient safety and quality improvement events will provide a valuable refresher on the latest standards, guidelines and best practice within anaesthesia.

A Practical Introduction to Quality Improvement
21 March 2018 | RCoA, London

Delivering Anaesthesia Safely
20 April 2018 | RCoA, London

Leadership and Management Events

This series offers a range of interactive workshops designed specifically for anaesthetists with a balance of plenary sessions, group work and exercises with the emphasis on real life issues, open discussions, up-to-date information and one-to one discussions.

Introduction to Leadership and Management
7-8 March 2018 | Novotel Hotel, Sheffield
30-31 May 2018 | RCoA, London

Leading and Managing Change
16 March 2018 | RCoA, London

LEADERSHIP AND MANAGEMENT EVENTS

This series offers a range of interactive workshops designed specifically for anaesthetists with a balance of plenary sessions, group work and exercises with the emphasis on real life issues, open discussions, up-to-date information and one-to one discussions.

Introduction to Leadership and Management
7-8 March 2018 | Novotel Hotel, Sheffield
30-31 May 2018 | RCoA, London

Leading and Managing Change
16 March 2018 | RCoA, London

Standard Trainee* Senior Fellow*
One day event £220 £165 £110
Two day event £395 £300 £250

GASAGAIN (GIVING ANAESTHESIA SAFELY AGAIN)

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.

RCoA, London
20 April 2018
Royal Bournemouth Hospital
11-12 June 2018

Gasagain Masterclass
9 March 2018 | RCoA, London

Airway Workshops
Topics include: fibreoptic handling skills, supraglottic airways, front of neck airway, awake fibreoptic intubation, video laryngoscopy, guidelines and human factors.

18 April 2018 | RCoA, London
13 June 2018 | RCoA, London

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

Standard Trainee* Senior Fellow*
One day event £240 £180 £120
Two day event £395 £300 £250

RESEARCH METHODOLOGY WORKSHOP
Joint RCoA, BJA & NIAA event

19 April 2018 | RCoA, London

This workshop is useful for anaesthetists of any grade who are already involved in research or those who are about to embark on a research project.

Sessions include:
- developing an idea (literature searches, critique of published work)
- analytical versus interventional research
- getting your study started
- presenting abstracts and posters
- getting it published

Standard Trainee* Senior Fellow*
One day event £150 £115 £75
Two day event £240 £180 £120

UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE

Our simulator-based course provides the knowledge, skills and attitudes required to safely manage the airway and post-intubation period in an emergency situation outside the operating theatre.

Wrexham Maelor Hospital
26-27 April 2018
Royal United Hospital, Bath
10-11 May 2018
Solihull Hospital
11-12 June 2018

Standard Trainee* Senior Fellow*
Price £240 £180 £120

ETHICS AND LAW

Familiarise yourself with legal and ethical issues that commonly arise in medical practice. The content has been mapped to the GMC’s Good Medical Practice domains for revalidation and CCT.

Topics include:
- introduction to medical law
- ethical issues in research and approval
- preparing for a coroner’s inquest
- DNACPR discussions.

9 May 2018 | RCoA, London

Standard Trainee* Senior Fellow*
Price £200 £150 £100

*Delegates must be trainee or senior fellow members of the RCoA to be eligible for the reduced rate.

Book your place at www.rcoa.ac.uk/events
What you can expect:

■ quick-fire specialist updates
■ informative keynotes from international experts
■ your choice of breakout sessions
■ live audience interaction and debate.

22–23 May
British Museum, London

#Anaesthesia2018

Book now:
www.rcoa.ac.uk/anaesthesia