Introducing the Lifelong Learning platform
## EVENTS CALENDAR

Further information about all of our events can be found on our website: www.rcoa.ac.uk/events

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### JULY
- **Final FRCA Revision Course**
  - 2–6 July 2018
  - RCoA, London
  - All days: £400
  - One day: £100

### SEPTEMBER
- **Advanced Airway Workshop**
  - 18 September 2018
  - RCoA, London
  - £260 (£175 for trainees)*

- **Clinical Directors Meeting: Joint with the AAGBI**
  - 19 September 2018
  - York Medical Society
  - Invite only

- **Leadership and Management: Personal Effectiveness**
  - 21 September 2018
  - RCoA, London
  - £240 (£180 for trainees)*

- **Developing World Anaesthesia**
  - 24 September 2018
  - RCoA, London
  - £220

- **FICM Preparatory Course**
  - 24–25 September 2018
  - The Studio, Leeds
  - £275

- **Developing World Anaesthesia**
  - 24 September 2018
  - RCoA, London
  - £220

- **Personal Effectiveness**
  - 21 September 2018
  - York Medical Society
  - Invite only

- **Clinical Directors Meeting: Joint with the AAGBI**
  - 27 November 2018
  - RCoA, London
  - Invite only

### OCTOBER
- **Updated in Anaesthesia, Critical Care and Pain Management**
  - 25–27 September 2018
  - RCoA, London
  - All days: £515 (£390 for trainees)*
  - One day: £210 (£160 for trainees)*

- **UK Training in Emergency Airway Management (TEAM)**
  - 8–9 November 2018
  - Royal Infirmary Edinburgh
  - £475

- **Leadership and Management: Working Well in Teams and Making an Impact**
  - 14 November 2018
  - RCoA, London
  - £240 (£180 for trainees)*

- **Joint Winter Scientific Meeting – Scottish Society of Anaesthetists**
  - 15–16 November 2018
  - Apex City Quay Hotel, Dundee

### NOVEMBER
- **UK Training in Emergency Airway Management (TEAM)**
  - 8–9 November 2018
  - Royal Infirmary Edinburgh
  - £475

- **Leadership and Management: Working Well in Teams and Making an Impact**
  - 14 November 2018
  - RCoA, London
  - £240 (£180 for trainees)*

- **Anæsthesists as Educators: Teaching and Training in the Workplace**
  - 8–9 October 2018
  - RCoA, London
  - £450 (£340 for trainees)*

### DECEMBER
- **Winter Symposium**
  - 12–13 December 2018
  - RCoA, London
  - All days: £420 (£315 for trainees)*
  - One day: £275 (£210 for trainees)*

### JANUARY
- **Tracheostomy Masterclass**
  - 11 January 2019
  - RCoA, London
  - £260 (£195 for trainees)*

- **Primary FRCA Masterclass**
  - 15–18 January 2019
  - RCoA, London
  - All days: £325
  - One day: £185

- **Airway Workshop**
  - 15 January 2019
  - RCoA, London
  - £260 (£195 for trainees)*

- **FPM Recent Advances**
  - 4–5 February 2019
  - RCoA, London
  - £175 (£110 for trainees)*

### MARCH
- **After the Final FRCA**
  - 6 March 2019
  - RCoA, London
  - £165

- **Leadership and Management: The Essentials**
  - 2–3 May 2019
  - RCoA, London
  - £420 (£315 for trainees)*

### APRIL
- **Cardiac Disease Symposium**
  - 3–4 April 2019
  - RCoA, London
  - All days: £420 (£315 for trainees)*
  - One day: £275 (£210 for trainees)*

### MAY
- **Introduction to Leadership and Management: The Essentials**
  - 2–3 May 2019
  - RCoA, London
  - £420 (£315 for trainees)*

- **Anæsthesists as Educators: Anæsthesists’ Non-Technical Skills (ANTS)**
  - 8 May 2019
  - RCoA, London
  - £235 (£180 for trainees)*

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

Book your place at www.rcoa.ac.uk/events
From the editor

Dr David Bogod

Welcome to the July Bulletin.

As you read this issue – assuming that it’s fresh out of the cellophane – the College is gearing up for the launch of its new Lifelong Learning platform, an online facility which we will be able to use to keep track of clinical experience, training, CPD, and reflection, and which will undoubtedly become an invaluable aid for providing evidence in support of appraisal and revalidation. Russell Ampofo and Aaron Woods make light of the work involved in developing this tool, but we at Red Lion Square have seen them metaphorically crying into their beer more than once over the last two years, and know that it has been quite an effort. Please try out Lifelong Learning once it goes live in August and let us know what you think.

For old fogies like me, the exam is a dim and distant memory. But I remember us asking exactly the same questions that Mike Wilkinson and Toni Brunning use in this issue to debunk common myths. Apparently, the College doesn’t spend all the exam income on wining and dining the examiners at the Ritz, there’s no secret fixed proportion of candidates who have to fail to keep the competition sharp, and you don’t have to be a posh bloke from a teaching hospital to become an examiner. And if that’s not reassuring enough, Andy Lumb and his colleagues at the Exams Department have undertaken two projects to examine differential pass rates amongst different candidate groups, as a preliminary to better targeting of pre-exam teaching.

It has been a bittersweet month for me, College-wise. The man who gave me my big break in anaesthesia by employing me as his research fellow, Mike Rosen, passed away in May at the good age of 90 years. His obituary within these pages describes what he did for our specialty, but I hope to be able to paint a more personal picture in a reflection I will be writing for the next issue. The week after Mike’s death, my old friend and colleague, Professor Ravi Mahajan, was elected as our next President. I am delighted, not only for the kudos that this will bring to our department in Nottingham, but because we have a leader for the next three years with a proven track record for wisdom, common sense, inclusivity and professionalism, a worthy successor to Liam Brennan. There is, I guess, a generation between Mike and Ravi, and they are very different people, but I am buoyed by a sense of continuity. As long as we have great leaders, we and our patients will continue to thrive.
As my presidency draws to a close I want to use my last President’s View to reflect on some of the highlights during my term of office which have coincided with a momentous time for anaesthesia and healthcare both here in the UK and internationally.

Taking a strategic approach

As I took office, Council and I were determined that the College should take stock and think carefully about our priorities and aims. Instead of using so much energy and resources responding to external events I was keen that we should define a five-year strategy to ensure that the College and the specialty continued to evolve, improve how we operate and meet future challenges impacting patients, members and our clinical and regulatory partners. Over the past two years the work of the College has been guided by our 2016 – 2021 Strategic Plan which reflects our vision for the future of anaesthesia.

Supporting anaesthetists, setting and maintaining standards, promoting the specialty and resourcing the future of anaesthesia are the four strategic goals the Council and I have set the College to deliver against.

Reviewing governance

At the same time as writing the strategy, Council also recognised the need for a comprehensive review of our governance structure – something not undertaken since the granting of our Royal Charter in 1992.

Since becoming a medical royal college we have grown enormously, and are now a thriving medium-sized business employing 100 staff, with an annual income of more than £13 million and total assets, including our headquarters in London, of more than £40 million.

I am pleased to say the May 2018 AGM approved Council’s proposed amendments to the Charter of Ordinances which will ensure smoother day to day running of your College. The changes include establishing a separate Board of Trustees with expert lay trustee representation; revising Council’s reporting processes and establishing student and foundation membership categories. A transparent, robust and relevant governance structure is a critical component of the success of any modern organisation and I am pleased the College now has this in place.

Looking after the workforce

There have been many areas of focus during my presidency, but the perennial problem of ensuring an adequately staffed and experienced anaesthetic workforce remains a top priority. Work in this area for me as president commenced with the launch of the College’s 2015 Medical Workforce Census. Rota gaps, attrition rates during core training and the fill-rates at specialist registrar level entry, the issues facing SAS grade colleagues, and the ageing anaesthetist are all key workforce issues which the College continues to address independently, or in partnership with a range of stakeholders. Latest results of our work on this can be found in our March 2018 Workforce Data Pack.
I am pleased that our efforts in partnership with colleagues in some of the hard to recruit to regions across the UK have been successful as the latest national recruitment figures appear to show a marked improvement compared to 2017.

As part of the College’s strategy to support anaesthetists throughout their career, a new membership service for undergraduates and foundation year doctors was introduced in November 2017. Alongside this, we also launched a new platform for undergraduate education in anaesthesia, critical care and pain medicine. Encouraging more students into a career in anaesthesia, is one way the College is working to address the current shortage of anaesthetists across the NHS. Critical to the development of the next generation of anaesthetists is the current shortage of anaesthetists across the UK, which has grown in stature over the past few years, is our international work. The College launched its first Global Partnerships Strategy in 2017, informed by the Lancet Commission report, which showed that five billion people worldwide lack access to safe, affordable surgical and anaesthetic care. This work is a key component of the College’s five-year strategy and represents a major opportunity for the organisation to meet its global responsibilities. This strategy is multifaceted and enables the College to work collaboratively with partners in resource rich and resource poor countries to share our experience in designing and delivering curricula and assessment methods.

Understanding welfare and morale

In response to increasing pressures reported by anaesthetists in training in December 2016 and January 2017 we surveyed them to better understand their experiences of life on the frontline of UK hospital care. More than 2,300 responded, representing 58 per cent of all anaesthetists in training. The results were worrying and received national press attention. To understand the concerns the survey highlighted, I ran a series of Listening Events across the UK. These events provided trainees with the opportunity to discuss the issues they faced with me, other members of Council and senior College staff in an informal and confidential forum. The survey and Listening Events culminated in the December 2017 publication of the Report on the welfare, morale and experiences of anaesthetists in training: the need to listen. Work on welfare and morale is ongoing and closely linked to joint efforts by the College and the AAGBI to tackle fatigue, which has the potential to affect all anaesthetists regardless of age, grade or experience.

Communications and external affairs

Over the past two and a half years the College has focused on developing an effective communications and member engagement function, which is raising our profile with members, key stakeholders and the public. The College is now speaking with a more authoritative and engaging voice. Our policy and external affairs work has also continued to evolve, with me and the chair of the College’s Northern Irish, Scottish and Welsh boards meeting frequently with politicians and policy makers in Whitehall, Westminster and in the devolved nations’ governments. In April 2018 we also successfully rebranded the College’s brand to better reflect the unique role of the College as a modern and forward-looking organisation. One publication, which needs no introduction, is the British Journal of Anaesthesia (BJA). As a benefit of membership to the College, the BJA’s impact factor has increased for the fourth consecutive year to 6.24, making it the world’s number one ranking anaesthetic journal, something the College and the BJA editorial board are rightly proud of.

Promoting global partnerships

Another element of the College, which has grown in stature over the past few years, is our international work. The College launched its first Global Partnerships Strategy in 2017, informed by the Lancet Commission report, which showed that five billion people worldwide lack access to safe, affordable surgical and anaesthetic care. This work is a key component of the College’s five-year strategy and represents a major opportunity for the organisation to meet its global responsibilities. This strategy is multifaceted and enables the College to work collaboratively with partners in resource rich and resource poor countries to share our experience in designing and delivering curricula and assessment methods.

More events

I was incredibly proud to host our largest ever Diplomates Day in May this year. With almost 400 diploma and 700 guests, this was the College’s largest ever event and stands testimony to the dedication, perseverance and hard work of the next generation of fellows of the College and associated faculties. Delivery of the College’s annual programme of educational events is a mammoth task. With hundreds of events having been held across the UK since the start of my Presidency, the latest and most high profile on the annual calendar in May this year was our new flagship event, Anaesthesia 2018 which was a sell-out success.

Raising clinical quality

In line with the College setting and maintaining the highest standards for anaesthesia, our flagship Anaesthesia Clinical Accreditation Scheme (ACSA) continues to flourish with over half of NHS trusts/boards across the UK now engaged with the scheme. This is a fantastic achievement, and now rightly recognised by both the Care Quality Commission in England and Health Inspectorate Wales who are considering ACSA accreditation status as part of their inspection methodology, demonstrating the esteem in which ACSA is held remains well-founded.

Supporting research

The College has continued to support high quality research and does so by working collaboratively through the National Institute of Academic Anaesthesia. Research projects led by the College include the internationally-renowned National Audit Projects, NELA, and SNAPs to name a few. Under my presidency, the College has taken great steps to define and implement a vision for perioperative medicine across the NHS. This is a core element of our strategy, which reaches across all College directorates. In May 2018 I was proud to open the conference launching NAP & focusing on perioperative anaphylaxis, which you can read about on page 11 of this issue of the Bulletin.

Investing in technology

Over the past two years, the College has been investing in a multimillion-pound technology programme to enhance the membership experience by modernising and integrating our member-facing technology and improving online accessibility and IT capability. The launch of the College’s new lifelong learning platform is now just one month away. Combining e-portfolio, CPD diary and logbook systems, this new platform will benefit thousands of members when it is launched in August.

Thank you

So as I hand the baton on to our new president, Professor Ravi Mahajan, a few thanks from me. To Council and the College staff for all their support during my term of office; to my colleagues at Addenbrooke’s Hospital, Cambridge for giving me the space to fulfil this important national role and to my wife and family – I couldn’t have done it without you!

And finally to you the fellows and members – thank you for the opportunity to serve you over the past three years. It truly has been an honour and a privilege.

Working with colleagues ST fill rates have improved by 10% rising to 96%
ANAESTHESIA 2018
a look back

The College held its first annual two-day international conference, Anaesthesia 2018, at the British Museum in May. This new event replaced the College’s Anniversary Meeting and Summer Symposium, combining the best of those two events, adding debates, quick-fire talks and interactive workshops to an already dynamic and varied programme.

Professor Stephen Powis, the Medical Director for NHS England, delivered the keynote address, sharing his personal reflections on delivering frontline care at one of the country’s largest foundation trusts, and giving his views on the innovations that might help to shape the future of healthcare.

Delegates also benefited from presentations and quick-fire talks on various topics including pain medicine, airway management, obstetric haemorrhage and the opioid. Professor Paul Myles shared with attendees an international perspective on the integration of patient care and perioperative medicine.

The highly anticipated panel discussion was chaired by the Health Service Journal’s Shaun Lintern and gave delegates the opportunity to put questions to key players in the health sector. RCoA President Dr Liam Brennan was joined on the panel by John Appleby (Director of Research and Chief Economist at the Nuffield Trust), Professor Helen Stokes-Lampard (Chair of the Royal College of General Practitioners), Professor John Appleby (Director of Research and Chief Economist at the Nuffield Trust), Professor Helen Stokes-Lampard (Chair of the Royal College of General Practitioners), Professor Mary Dixon-Woods (RAND Professor of Health Services Research at the University of Cambridge), who discussed the big issues influencing the NHS and anaesthesia.

Thanks to all speakers for giving their time to share expertise and knowledge over the two days. We hope all attendees enjoyed the two days of learning, networking and discussion.

Fluid fasting before general anaesthesia in young children

The College supports the joint consensus statement from the Association of Paediatric Anaesthetists of Great Britain and Ireland, the European Society for Paediatric Anaesthesiology and L’Association Des Anesthesistes-Reanimateurs Pediatriques d’Expression Francais on updated fluid fasting guidelines for children prior to elective general anaesthesia. The joint consensus statement can be found here: bit.ly/fluidfasting_pa.

Based on the current convincing evidence base, unless there is a clear contra-indication, it is safe and recommended for all children able to take clear fluids, to be allowed and encouraged to have them up to one hour before elective general anaesthesia.

A special interest article providing further information is available in Pediatric Anesthesia: bit.ly/fluidfasting_pfa.
A big thanks to the NAP6 review panel and the dedicated NAP6 local coordinators who made the study possible.

The highly-anticipated launch of NAP6!

The 6th National Audit Project (NAP6) of the College, Anaesthesia, Surgery and Life-Threatening Allergic Reactions, was launched at the Royal Society of Medicine on Monday 14 April 2018. The largest ever prospective study of anaphylaxis related to anaesthesia and surgery, NAP6 investigated every case of life-threatening anaphylaxis during three million anesthetics given in the UK over one year. The full report can be downloaded at bit.ly/rcoa-nap6.

Antibiotics were identified as the most frequent cause of anaphylaxis, in contrast with previous studies which found the main culprit to be muscle relaxants. Teicoplanin, regularly used for patients who reported allergy to penicillin, was 17-fold more likely to cause anaphylaxis than penicillin and similar drugs. As 90 per cent of patients who report penicillin allergy are in fact not allergic, better identification of true allergy would reduce risk.

While most patients survived their anaphylactic reactions, 40 had a cardiac arrest and 10 patients died. Patients at most risk of cardiac arrest or death were the elderly, those with cardiac disease, those taking certain cardiac medicines and the obese. Also of concern was the average waiting time of more than 100 days for patients to attend an allergy clinic.

Report author Professor Tim Cook said: “We have identified areas where changes might reduce the risk of anaphylaxis and others where improvement is required such as during management of the most severe cases.”

A big thanks to the NAP6 review panel and the dedicated NAP6 local coordinators who made the study possible.

PQIP releases first Annual Report

The Perioperative Quality Improvement Programme (PQIP) has published its first Annual Report. PQIP, a research study being led by the National Institute of Academic Anaesthesia Health Services Research Centre, working on behalf of the Royal College of Anaesthetists and a range of stakeholders, aims to improve patient outcomes from major surgery. Hospitals collect data on patient characteristics, quality of care and postoperative complications – patients provide their own feedback on satisfaction with care and longer-term quality of life.

Since PQIP started in December 2017, over 6,500 patients have been recruited from 79 hospitals across England, with sites in Scotland and Wales due to join soon.

The 2017-18 Annual Report outlines PQIP’s top five national improvement opportunities for 2018-19, including a focus on individualised risk assessment, adherence to enhanced recovery principles, and the optimisation of anaemia, diabetes, and postoperative pain.

The report can be found at bit.ly/pqip-annualreport. A personalised report of local data for every participating hospital is also available – contact your PQIP principal investigator for a secure login to www.pqip.org.uk.

ACSA on the road

With more than 50 per cent of hospital trust/boards in the UK engaged in Anaesthesia Clinical Services Accreditation, there’s plenty keeping the clinical quality team busy!

The past few months has seen the College host some of its biggest events of the year, with Diplomates Day, Anaesthesia 2018 and the Updates meeting all seeing hundreds of delegates interact with the work of the College and its staff. The ACSA team has been at each of these events and had delegates from anaesthetic departments across the country engage with us to learn more about ACSA and how their hospital can engage in the quality improvement scheme.

To arrange for the ACSA team to present at your department please email ACSA@rcoa.ac.uk. If you are interested in becoming an ACSA panel member please contact your PQIP principal investigator for a secure login to www.pqip.org.uk.

The report can be found at bit.ly/pqip-annualreport. A personalised report of local data for every participating hospital is also available – contact your PQIP principal investigator for a secure login to www.pqip.org.uk.

Inspiring the future

The College actively promotes the work of our specialty with patients and members of the public. Last month representatives from the College attended the Annual School Science Conference at the University of Westminster. With approximately 300 young people attending, the event was a valuable opportunity to showcase our specialty and to share with students information about the work of anaesthetists and intensivists.

Four energetic and enthusiastic anaesthetists in training attended the event on behalf of the College, sharing tips, information about medical and anaesthetic training, and giving interactive demonstrations to GCSE students. It was a positive experience for them, as their feedback below suggests: “I was demonstrating the use of ultrasound to identify and distinguish arteries from veins. A very rewarding day and one which I would very much involve myself in the future.”

Dr Lina Fazlanie
Education Fellow at the RCoA

“I’m lucky to have an incredible job and I want to ensure the next generation understand what it is we do and encourage them to consider anaesthetics as a possible career option.”

Dr Karen Stacey FRCA
Specialist Registrar, Imperial School of Anaesthesia

“We spoke about the role of the anaesthetist and encouraged students to interact with airway and ultrasound equipment. Hopefully we’ll see some of the students back at the College in the future as budding anaesthetists!”

Dr Helen Church MRCA
Consultant, Chesterfield Hospital

“Today’s Year 9-11s are tomorrow’s doctors! A large proportion of the children had had an anaesthetic before and were really pleased to spend a bit of time learning about the people who took care of them while they were ‘sleeping’.”

Dr Safeena Afzal FRCA
ST5, University College London Hospital
Since the founding of the NIAA we have given approximately £6m to research in support of our charitable aims.

In the same package that brought you this issue of your Bulletin you will have received the British Journal of Anaesthesia (BJA) and the British Journal of Anaesthesia Education. These are benefits of your membership of the Royal College of Anaesthetists, and an indication of the close working relationship between two organisations with very similar objectives.

Founded in 1923, BJA remains the oldest and largest independent journal of anaesthesia, and is currently ranked number one in category based on impact factor. You may also have noticed BJA has moved publishers from Oxford University Press to Elsevier, that between two organisations with very similar objectives. These are benefits of your membership of the Royal College of Anaesthetists, and an indication of the close working relationship between both organisations, and to recognise that the College and the BJA are two independent charities. The BJA is also the official journal of the College of Anaesthetists of Ireland and the Hong Kong College of Anaesthetists. The board of BJA meet twice per year, and our directors meet at least four times per year including the two main board meetings. The following committees of the journal feed into the decisions made by the directors: (i) the BJA Editorial Committee, (ii) the BJA Education Editorial Committee, and (iii) the Grants Committee. Governance and Nominations Committees are currently working up terms of reference. Within our editorial board there is the BJA–Editor in Chief (EiC), and eight main editors plus CME and Letters editors and the BJA Education–EiC. These are remunerated within a budget envelope determined between the EiCs and the directors. The BJA is also served by an associate board of 30 people, excluding co-opted non-voting members. As you would expect for an international journal, about half the board members are from outside the United Kingdom. There is a board of directors comprising six voting members with the following portfolios: (i) chair, (ii) administration, (iii) finance, (iv) governance, (v) business development and grants (this member also chairs our Grants Committee), and (vi) a lay director. Until recently the RCoA president has served as a voting director. This year a new BJA–RCoA liaison group was established to foster closer links and enhance communication between both organisations, and to recognise that the College and the BJA are two independent charities. The BJA is also the official journal of the College of Anaesthetists of Ireland and the Hong Kong College of Anaesthetists. The board of BJA meet twice per year, and our directors meet at least four times per year including the two main board meetings. The following committees of the journal feed into the decisions made by the directors: (i) the BJA Editorial Committee, (ii) the BJA Education Editorial Committee, and (iii) the Grants Committee. Governance and Nominations Committees are currently working up terms of reference. Within our editorial board there is the BJA–Editor in Chief (EiC), and eight main editors plus CME and Letters editors and the BJA Education–EiC. These are remunerated within a budget envelope determined between the EiCs and the directors. The BJA is also served by an associate board of 36 members. There is an independent board of 18 for BJA Education.

Like most organisations, BJA has income and expenditure, and as a charity these need to match our charitable aims. These are (paraphrased): ‘to advance knowledge and skills in all branches of anaesthesia, critical care and pain medicine… and to disseminate related knowledge and skills…’. The greater part of our income derives from academic subscriptions and consortia sales. Our biggest single group for individual copies of our journals is you – the fellows and members of the Royal College of Anaesthetists for whom the BJA is your official journal. Currently the College makes a contribution to the BJA on behalf of each fellow and member for your journals – each year, 12 issues each of BJA and BJA Education, plus six editions of the RCoA Bulletin. An additional income stream is derived from our (ethical) investments. The BJA has a managed portfolio designed to generate at least £750,000 income (revised upwards from £500,000 at the end of 2017), to disburse in the form of grants for anaesthesia and its related specialties. This funding is disbursed via NIAA processes on the advice of our Grants Committee. We also financially support NIAA structures and educational activities. Our investment income is used to fund undergraduate research projects in the form of John Snow intercalated student awards, clinical research training fellowships (clinical PhDs – jointly with the Medical Research Council), non-clinical PhD studentships, project grants (now exceptionally up to £100K each), large clinical and non-clinical career development awards, and a growing portfolio of international awards. Since the founding of the NIAA (BJA is one of the founding partners) we have given approximately £6m to research in support of our charitable aims.

I hope that you now have a little better understanding of the way BJA works and that when you have finished reading this Bulletin you will make a start on your copy of the BJA and BJA Education. Access to these titles is a fantastic RCoA membership benefit, and I hope you can now see that the funding made available to ‘team anaesthesia’ from BJA in some small measure comes from your subscriptions as fellows and members, and, importantly, as readers of, and contributors to our journals.

Reference


Professor David Lambert
Chair of Board of British Journal of Anaesthesia

Guest Editorial

British Journal of Anaesthesia – your official journal

In the same package that brought you this issue of your Bulletin you will have received the British Journal of Anaesthesia (BJA) and the British Journal of Anaesthesia Education. These are benefits of your membership of the Royal College of Anaesthetists, and an indication of the close working relationship between two organisations with very similar objectives.
Professor Michael Rosen CBE, the first (and only) President of the ‘College of Anaesthetists’ after its establishment but before it was granted its royal charter, passed away after a long illness, borne with characteristic humour, grace and fortitude, on 2 May, 2018.

Michael Rosen was born in Dundee in 1927 to Israel and Lily. One of four siblings, two sisters died in the first few years of his life and his brother in his thirties. He attended Dundee High School before studying medicine at St Andrews, the first in his family to attend university. After qualification in 1949, he joined the RAMC, where he rose to the rank of captain and served in Egypt and Cyprus.

Michael trained in Bradford, Newcastle-upon-Tyne and Cleveland, Ohio, gaining his Fellowship in 1957. He was appointed in 1961 to a consultant post in Cardiff, where he spent the rest of his working life. At that time, the Cardiff anaesthetic department was pre-eminent, and he worked alongside such luminaries as Professors William Mushin and Bill Mapleson. During this time, he published over 170 papers, and edited or wrote seven books. He was awarded a personal chair in 1983, the first non-university NHS post holder in Cardiff to be so honoured.

Michael’s early career was marked by a flurry of research projects, and he rightly identified his work on standards for medical suction as being a landmark in anaesthesia. His enthusiasm and drive were legendary, and although some of his research proposals were, to those of more pedestrian outlook at least, rather fanciful, they were nothing if not visionary. It is as a medico-political leader that Michael will be most remembered, however. Never lacking in ambition or vision, he was the ideal person to lead the AAGBI to its then new home in Bedford Square, serving as President between 1986 and 1988. Perhaps his greatest achievement was in persuading the anaesthetic establishment in the late 80’s that the time had come to move out from under the wing of the Royal College of Surgeons. Until then, the Faculty of Anaesthetists had lived in offices in the surgeons’ building in Lincoln’s Inn Fields, but Michael argued cogently, often against strong opposition, that the largest hospital specialty needed its own College. In 1988, the Faculty became the College of Anaesthetists, and moved into premises in Russell Square. Michael was elected as the first President of the College the same year, and his term of office ended in 1991, the year before the Royal Charter was granted.

Michael maintained a variable collection of research fellows, both from the UK and overseas, and treated them all with great kindness and generosity, often acting as loco parentis, and not infrequently quietly putting his hand into his pocket to help them with financial problems. Many of his protégés are now to be found at the forefront of anaesthetic practice and research around the world. His concern for others also resulted in his working with Kenneth Rawnsley, Professor of Psychiatry in Cardiff, to pioneer the innovative ‘Sick Doctor Scheme’ for anaesthetists in the mid 1970’s, which ultimately led to the formation of the National Counselling Service for Sick Doctors at the British Medical Association.

During his long career, Michael’s contributions were recognised by many national and international bodies. He was awarded honorary fellowship of both the Association of Anaesthetists of Great Britain and Ireland and of the Obstetric Anaesthetists’ Association.

His passion remained undimmed in his later years, when he focussed his attention on achieving standards for pain relief for babies undergoing ritual circumcision. His Jewish faith, although never in the foreground, was an important and abiding comfort to him, and many Cardiff co-religionists will recall, often with a shudder, being given a mandatory tumbler of whisky to break their 24-hour Yom Kippur fast chez Rosen.

Notwithstanding his professional passions and his relentless drive, his family was the very heart of Michael’s life. He married Sally in his 20’s, and they were together for 62 years. He described her as the centre of his thoughts, trusted her judgement entirely, and loved her deeply. They were immensely proud of their three children, Timothy, Amanda and Mark, their eight grandchildren and great-grandchild. In his latter years, Michael suffered from increasingly debilitating Parkinson’s disease. Despite this, he maintained his impecable appearance, helped by an extensive collection of cashmere sweaters of all pastel shades. Always a firm believer in the motto ‘mens sana in corpore sano’, physical fitness was important to him and, up until his 88th year, he was a regular at the local gym. When his beloved Sally passed away, he decided, in his typically determined way, that his life on earth was completed. A firm and vociferous believer in the individual’s right to choose the method and time of his passing, Michael, greatly weakened by his illness, felt he had no legal alternative other than to refuse to eat, and he followed her two weeks later. Those who saw them together could never imagine them apart.

Dr David Bogod  
Former Research Fellow, University Hospital of Wales and RCoA Member of Council
Faculty of Pain Medicine (FPM)

Training and Assessment Committee: update

In the last few months, the committee has been analysing information from the most recent pain census, planning the pain-curriculum rewrite, and analysing the impact of GMC credentialing on pain medicine.

The pain medicine workforce census was completed in the autumn of 2017, and a full summary has been published. There was a 76.8% response rate and this time the census went beyond recording only demographic information. It also made enquiries as to chronic, acute and paediatric pain working patterns, multidisciplinary involvement, SPA support, and asked whether recent tax and pension changes have influenced retirement planning. As the majority of pain specialists who responded stated that they were over 50 years old, there remains a skewed workforce that could see a flurry of retirements within a short timeframe. It has been noted separately that the uptake of advanced pain training posts has also been lower in recent years. Ongoing monitoring of both situations will be required to ensure pain training throughput remains sufficient in the coming years.

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The curriculum rewrite for pain medicine is running in parallel with the RCoA’s curriculum rewrite, and will see the creation of generic and specialist pain medicine competencies. The former will be developed at early stages of training, while the latter will be assessed within higher and advanced training. Overall it is hoped that the burden of assessments will be simplified to give fewer, higher-level outcomes.

Alongside this process, we have another working group which is at the preliminary stages of developing advanced pain training as a credential under the GMC’s new training proposals. We hope this will provide a GMC-endorsed recognition of pain training and will also allow access to advanced pain medicine by a broader group of specialists, which may help to mitigate the future workforce shortfall identified by the census.

Faculty of Intensive Care Medicine (FICM)

Key FICM training updates

Stage 2 ICM/higher anaesthesia specialist modules are dual counted for both programmes since some competencies can be acquired in either an anaesthesia or an ICM placement. However, some can only be acquired in theatre or on the intensive care unit, and the College and Faculty have agreed that dual anaesthetists in training, during their Stage 2/higher anaesthesia specialist modules (paediatric, neurosciences and cardiothoracic), should spend some time in both theatre and the intensive care unit. A dual anaesthetist in training appointed in ST5 to the ICM training programme having commenced their higher anaesthesia training, will have any specialist module undertaken as part of higher (but not intermediate) anaesthesia training counted towards their Stage 2 ICM training, assuming the appropriate ICM competencies have been signed off by their Educational Supervisor.

As a result of a change to the examination regulations, it is now possible to sit the FFICM exams (MCQ and OSCE/SOE) within 10 (previously 7) years of passing the relevant Primary exam.

When the newly approved Royal College of Physicians Internal Medicine (IM) curriculum is introduced in 2019, physicians in training will spend three months in ICM in Year 2, to prepare them for the role of Medical Registrar in IM Year 3. The RCP and Faculty have worked closely together to implement this, and we encourage regions to facilitate this welcomed training initiative.

The Faculty had a preliminary meeting with the GMC to discuss our curriculum rewrite and how it meets the new standards required by the GMC and the requirements of the Shape of Training review. We presented our position, which was then discussed in depth, and the GMC have asked the Faculty to provide answers to specific questions and to provide further data to support its curriculum submission. A further meeting is planned with the GMC in the autumn.

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Patient Perspective

Should Aunt Dot be worried?

When I decided to retire after working full time for more than 30 years, I wondered how I would spend my new-found freedom. I need not have worried, for no sooner had that thought entered my head than the phone started ringing. I seem to be at that age when everyone around me is falling apart healthwise. Last year in my circle of family and friends we had three cases of bowel cancer and one of prostate cancer, two had spinal operations and two had knee replacements, and on top of that there were five deaths! So, as you can imagine, I’ve had a fair bit of hospital visiting and writing of get-well cards.

As the family and friends are spread across the country, it has been interesting to see and hear of variations in treatment and care. On the whole, surgery has been very successful, but information and postoperative pain control varied. Improvements could always be made in this area.

Looking ahead to the next five years, we have updated our guidance on patient and colleague feedback and on continuing professional development (CPD). Both documents, which are available on our website, have been made more concise, and also feature real-life examples based on questions received in our Revalidation Helpdesk. For example, the role of the employer in CPD, the required quantity of patient feedback returns and the need to give special consideration to be given to seldom-heard groups.

Focusing on CPD, we are keen to hear from members who would be willing to act as a CPD Assessor in reviewing the event applications which we receive for approval. Plans also include a much more user-friendly method for CPD Assessors to complete their event reviews, which is another good reason to get involved in this important role.

For further information on any of the above please contact Chris Kennedy, Revalidation and CPD Coordinator at ckennedy@rcoa.ac.uk.

Reference

1 Date Explorer resource, GMC http://bit.ly/2jEJkhK

Revalidation for anaesthetists

Revalidation: the next five years

It has now been five-and-a-half years since the launch of revalidation and, as of 1 May 2018, the GMC had reviewed 236,026 submissions of which 81% had been revalidated whilst 18.7% had been deferred. Detailed information is available from the new Data Explorer resource on the GMC website.1

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Think about what excites you and what skills you have to contribute

I was elected to one of the two SAS seats on College Council. Until three years ago, one of these seats had been vacant for some time because nobody came forward to stand for it. There has been a lot of behind-the-scenes work to move SAS issues up the College agenda, and the SAS Committee has recently been reinvigorated, and has representation from around the country. Look out for advertisements in the Bulletin for vacancies or for vacancies on the boards in the devolved nations (all of which have an SAS member now, which is most encouraging). This enables the SAS perspective to be reflected at all levels of College work.

If you have a particular subspecialty interest, you might consider applying to join the appropriate GRAS chapter-development group. GRAS (Guidelines for the Provision of Anaesthetic Services) is the living document that sets our anaesthetic standards, and it is constantly being updated. The chapter-development groups include anaesthetists of all grades. Further information can be found on the College website [http://bit.ly/2e5s3ni]. Most of the work of these groups is done electronically, and so is a bit more manageable if it will be difficult to get time out of work.

RCoA allows SAS doctors to be examiners, but you must have your fellowship. This is a big commitment but is tremendously rewarding. As well as attending the examinations themselves, there is a lot of work writing questions and quality assuring the exams. More details can be found at [http://bit.ly/rcoa-examiner].

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) is the other national membership body for anaesthetists. They also have an SAS Committee, which is chaired by Oliviera Potparic. They are very involved in developing and delivering educational content for AAGBI. The membership department at AAGBI is considering how to engage better with SAS grades, so look out for any news. The AAGBI has also produced an excellent SAS Handbook which is available on their website [http://bit.ly/2JlH5dJ]. This will be regularly updated.

The other major national body you could get involved with is the British Medical Association. This is for all doctors, and has a much more political remit. Some people feel very strongly about subjects such as contract negotiations, the state of the NHS, and social care more widely. Places to start include your regional SAS meetings. Details can be found at [http://bit.ly/2PArhEm]. Each regional committee sends a representative to the national SAS Committee. More information can be found on the SAS pages of the BMA website.

You do not need to limit yourself to SAS issues. The BMA has a lot of other specialist committees, and sometimes when you put yourself forward for one thing, you are asked to consider another. Anthea Mowat is an Associate Specialist in anaesthesia and chronic pain, and is currently the Chair of the BMA Representative Body. She regularly speaks at meetings to encourage SAS doctors to be ambitious and maximise their potential, and she spoke at the excellent AAGBI SAS Seminar last year, stressing the importance of loving the job you have and carefully considering your work and non-work values. This will help you to identify what really matters to you and to prioritise your development needs accordingly. What is holding you back? Are some of these things within your control? They may be personal attitudes and confidence. Some external factors may also be modified after discussion with the right person. Some things are just outside your control and have to be accepted.

You need to set realistic and achievable goals for career and personal development. You may have an excellent supportive and appraisal process to assist with this. Other options include mentoring, which may be available in your trust or through the AAGBI. This can be a useful tool to help you discover more about yourself and consider what direction might be appropriate right now.

Hopefully you now have a flavour of what you could consider. This is not an exhaustive list of suggestions – think about what excites you and what skills you have to contribute. Be persistent – not achieving your goals should prompt reflection and reappraisal. There is something to learn from setbacks. Use that to fuel your development, not ambush it.
The Clinical Directors’ Network

Dr Dan Connor
RCoA Clinical Directors’ National Executive Committee

In the March Bulletin, David Selwyn introduced the Clinical Directors’ Network and also the Clinical Directors’ Executive Committee. I joined the Executive Committee at its inception when I was clinical director in Portsmouth and engaged with a fledgling regional network of CDs. Since finishing as CD I have continued in a variety of managerial and leadership roles, though mostly within the military – they pay my wage!

Many of the challenges facing individual CDs are common to all of them. The Clinical Directors’ Network has an active online discussion forum which acts as a resource to provide support in some of these challenges. The following questions have been asked by CDs many times. The answers are not exhaustive, and are by no means only relevant to CDs.

In job planning a department of 60 doctors, how can I as a CD ensure adequate time to undertake the process fully? Involving looking at performance data and annual-leave use, I think it takes 2–4 hours for each job-plan review? The job plan of a CD should set out the average time commitment. The Clinical Directors’ executive can put you in touch with CDs who run similar size departments for further advice/support.

Should any consultant be allowed to work 24 hours continuously by linking on-call time to a day’s scheduled work? Surely this is the reason on-call is onerous. Yes. An individual can opt out of the European Working Time Directive restrictions. Equally, many on-calls are not onerous, and so working the following/preceding day may be of no consequence. The GMC’s Good medical practice¹ and the AAGBI glossy Working arrangements for consultant anaesthetists² provide guidance on the implications of working while tired and also on the timing of on-call periods. However, if you have a problem with recurrent (and therefore predictable) loss of DCC the day after being on call, then the above documents support you in prospectively job planning away from DCC the day after an on-call. A partially flexible job plan can be helpful in this situation.

Is there a hierarchy in which external organisations should be supported through SPA and Additional Duty PAs? No. Support for external work was supported by 65% of trust/boards in a College survey. However, there is no hierarchy or prescribed level of support. Health Education England has previously written to all CEOs requesting that external NHS activity be supported, but the level of this support is at the discretion of individual trusts/boards. Guidance from the Association of Medical Royal Colleges states that external roles should be supported through Additional NHS Responsibility allocation rather than through standard SPA. However it is often a pragmatic negotiation between the CD and the individual, with support from the divisional or medical director. Ideally, there will be a trust-wide policy for external roles/duties, ensuring equality of opportunity and access. Sometimes it will not be possible for external activity to be supported (there are only so many external activities one ‘overachieving’ department can manage). Individualised arrangements are key, though sometimes these may need to be quite creative. Equally, appreciation that these roles may also benefit the individual over time is relevant for consideration during the job planning of new or established external roles.

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References
Launching the Lifelong Learning platform

The new RCoA Lifelong Learning platform launches in August 2018 after two years of intense project development, and aims to improve the support of training, assessment, reflection and learning, and (in time) revalidation.

The new web-based platform integrates elements of the previous system (for example, PDP, MSF, ARCP, ESSR, Placements, Milestones and Certificates), and combines these with logbook functionality in a fresh and intuitive interface. Access to the platform is free to all members and will also be provided to supervisors and deanship administrators.

Guided by the College’s Technology Strategy Programme (TSP), the project team has worked closely with training team colleagues and Nomensa (our technical partner). In addition we have collaborated widely with over a hundred individuals, including anaesthetists in training, trainers, consultants and SAS doctors from the wider membership, as well as other NHS colleagues. This collaboration included work on specifying the software requirements, the appointment of the supplier (procurement), defining and refining user journeys and, critically, thorough user-led testing.

Transition

We have been lasing with schools of anaesthesia since February 2018 to help them prepare for the transition to the new system. In August, we will start by adding to the platform new CT1s, new ST3s, new ST5s, MTI and career-grade doctors, all trainers, and College administrators. This will be done in a stepwise approach to minimise disruption.

After the new system goes live in August 2018, accounts will be created on the new platform for all other anaesthetists in training once they have notified the College that they have commenced their next respective level of training, for example, intermediate or higher level (receipt of registration forms for CT1s and ST3s, and Intermediate Level training certificates for ST5s will be taken as notification of this). Some anaesthetists in training will need to transfer in the middle of a training level, and schools of anaesthesia will be responsible for ensuring that these trainees are supported and that they are minimally disadvantaged during the ARCP process.

Support and the future

We will continue to promote the new platform at key events, and we are currently in the process of releasing concise training guides and videos. Training is focusing on a ‘train the trainer’ approach, and will be done on a regional basis rather than as individual training, as the platform is much more intuitive than the previous system. This will backed up by a series of regular webinars as well as responsive and flexible user support.

Support for the old e-Portfolio system will end in August 2019.

Future planned and related changes

- Offline functionality for logbook features
- CPD functionality in order to support users throughout their career in anaesthetics
- Future integration with a new RCoA member web portal
- A self-service portal for call logging and support to allow 24/7 self-service for users in order to enhance the recording and resolution of user questions, calls and change requests.

Key features

- Accessible, engaging and intuitive design.
- Mobile-ready and supports common web browsers.
- Support for multiple and changing curricula.
- ACCS (Anaesthesia)-supported.
- Flexible administration, eg, to enable school administrators to complete tasks using specific permissions according to their roles within the system and the organisation.
- Reporting, eg, heads of school and deans have an overview of all the trainees in their area.
- High level of data security via a resilient web server.
- Open and flexible data architecture, with the College retaining intellectual ownership of the software code for its own use in the future.

Summary

This collaborative project aims to create a step-change improvement in the experience of all our members in their training, assessment, reflection and learning as well as establish a firm basis for the College to invest in future improvements in this area.

As we approach completion of this work, we would like to thank our members who have been involved throughout the process. The vast changes and new features that you will find in the Lifelong Learning platform, which make it such an advance from the existing e-Portfolio, are a testament to the challenges posed by the creation of a better experience for anaesthetists in measuring progress against the curriculum and easing the process of review at ARCP.

If you have any questions about implementation in your region, or would like to see what the new platform will look like, speak to your local Lifelong Learning lead (these are listed on our website).
The National Emergency Laparotomy Audit (NELA) aims to improve the care of emergency laparotomy patients through the information gained in the audit. Indeed, it would be a wasted opportunity to gather the data and not use it to help us improve. As well as providing comparative data, NELA can help sites improve by aiding the development of quality improvement (QI) initiatives and spreading best practice.

To help hospital teams use their NELA activity to improve care, we funded and ran eight regional QI workshops around England and Wales. These were arranged by local leads in conjunction with the NELA project team. We had attendees from surgical, theatre nurse, anaesthesia, intensive care, management and clinical audit backgrounds. Based on suggestions from department NELA leads, the workshops included sessions on QI methodology, approaches to implementing change, and getting the best from your NELA data. There was plenty of time for discussion between participants on what they do well and what they find difficult, both to perform well in the audit, and more generally to provide the best care to emergency laparotomy patients.

Delegates worked in groups to create driver diagrams and process maps for their local emergency laparotomy care, and talked through the whole patient pathways, from initial presentation to hospital discharge. It was fascinating to see the range of approaches used to provide care for these high-risk patients, and the different approaches to common problems.

We saw many varied strategies for risk estimation, which was often tied to theatre-booking procedures, and was in many cases part of newer electronic health record systems. We saw a range of approaches to rehabilitation before hospital discharge, use of enhanced recovery principles and many departments talking about their approach to provision of care of the elderly liaison services, many of which are still work in progress.

The NELA project team learned a great deal from listening to these discussions, and had time at the end of the workshop to get feedback on what you want from the audit. As a result of delegates’ feedback, the NELA team is now working on providing help with care of the elderly liaison service business cases, infographic templates, report formats more suitable for governance, and sharing more laparotomy pathway documents.

User suggestions will also feed into the redesign of the NELA webtool and the QI dashboard to create more useful data analysis and charts for local improvement initiatives.

Feedback from the workshops was very positive, with 99% of delegates saying that they found the workshops valuable, and reporting increased agreement with the statements:

- “I can improve the delivery of care to patients undergoing emergency laparotomy using information produced by the audit.”
- “I can develop effective change (quality improvement) plans for our emergency laparotomy pathway.”
- “I am aware of examples of best practice in emergency laparotomy care.”

Look out for more regional events in 2018, and for the changes that delegates suggested coming from the NELA project team soon.

We are very grateful to the local leads. Without their help and enthusiasm these events would not happen.

Thanks to the local leads who assisted in providing these regional workshops: Barry Appleton (Wales), Dave Saunders (North East), Alastair Williamson and Helen Hunt (West Midlands), Tom Owen (North West), Stephen Webb and Nicole Greaves (East of England), Carolyn Johnston (London).

### Feedback comments from local teams

- “Would be more useful sending some local NELA laggards to see if you would manage to engage them!”
- “I enjoyed hearing the national perspective of NELA.”
- “Very good – especially interactive bits; good format for informal discussion between specialties and units.”
- “It was really useful to have discussions in workshops about what other hospitals were doing.”
- “Found the QI parts helpful, especially driver diagrams.”
- “I am aware of examples of best practice in emergency laparotomy care.”

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**Example activity**

Attendees worked in groups to make a driver diagram for reducing length of stay in emergency laparotomy patients. This shows the primary and secondary drivers (or factors) that might contribute to reducing length of stay. This helps break down a bigger problem into component parts. You can see more about driver diagrams on [http://bit.ly/NELA-videos](http://bit.ly/NELA-videos)
Calling all anaesthetists in training and trust doctors!

An opportunity to get involved with PQIP and drive local quality improvement

Dr Duncan Wagstaff, Dr Arun Sahni and Dr James Bedford
PQIP Research Fellows and Anaesthesia Trainees
Professor Ramani Moonesinghe
PQIP Chief Investigator, Director NIAA Health Services Research Centre

PQIP published its first annual report in April 2018 (www.pqip.org.uk/pages/ 2018). The report identified five national improvement priorities for perioperative care (Figure 1). Every one of the 80 hospitals taking part in PQIP so far can find at least one thing on this list to focus on. PQIP is evaluating the care and outcomes of adults having major surgery, and with a major complication rate of 11%, evidence of poor detection and management of some co-morbidities, and 19% of patients reporting severe postoperative pain as well as other adverse outcomes, there is plenty of work to be done!

You might be surprised to see how patients are doing a week after their operation when many anaesthetists will feel that their duty of care has ended. A great training opportunity in itself.

Talk to patients. Working with research nurses and local principal investigators to screen and consent patients is a great opportunity to get research experience. We also contact patients 6 and 12 months after surgery to ask them about their recovery and quality of life. Speaking to patients after they leave hospital is an interesting and humbling experience, and will give you a different perspective on the role of the anaesthetist and perioperative physician.

Collaborate with other anaesthetists in training to deliver QI, submit abstracts, and get published. Working collaboratively on PQIP data should overcome the usual barrier to anaesthetists in training taking part in meaningful QI – ie, frequent rotation between different hospitals.

So, what do you do now?

■ See which hospitals are taking part in PQIP (https://pqip.org.uk/pages/sites).

■ If your hospital is involved already, find out from your local lead if they have any projects up and running or ideas you can take forward. How are they using the local data already? Can you help with increasing QI awareness, for example by presenting local data to departmental or managerial meetings?

■ Ask them for access to your hospital’s data, and watch our video about how to use the database to extract data for QI projects (https://pqip.org.uk/pages/video_resources).

■ If your hospital is not already in PQIP, speak to the College tutor, research or governance lead and see if they would be interested in joining. Any UK hospital that performs major surgery in adults (colorectal, upper GI, HPB, head and neck, urology, plastics and complex orthopaedics) can take part. PQIP is a research study on the NIHR portfolio, so hospitals can get help from research nurses to screen and consent patients and collect data.

■ Contact us on pqip@rcoa.ac.uk and we’ll do what we can to help you!

Instead of another heart sink, PQIN or anaesthetic machine check audit, do something good for your patients, your department, your hospital and yourself. Getting involved with PQIP will not only satisfy the ARCP requirement for a quality improvement project, but will also make a real difference to patients. PQIP and other national projects such as NELA and the hip fracture audit all present great opportunities to do this and be recognised for your efforts. PQIP listed nearly 300 collaborators in its first report. Make sure you are on that list next year!
It is with great sadness that we announce that on 11 May the College received notification of the news of the passing of Chantelle Edward, Event Manager. Chantelle was a valued and long-standing member of staff, who was the welcoming face and manager of many of the College’s events over the past 18 years.

Chantelle joined the College in September 2000 and was the fourth longest serving member of staff. Chantelle started at the College as an Assistant Conference Administrator, and her main role was to process the hard copy delegate registration forms for educational events. Even at this early stage in her career at the College, Chantelle displayed all the necessary skills for a successful conference organiser. She was extremely well organised and she was regularly praised for her attention to detail and her ability to resolve complex issues.

Chantelle excelled and gained a comprehensive overview of the events operations and was soon appointed to take up a more senior, managerial position as Events Supervisor in 2005. As part of this role, Chantelle was responsible for providing managerial oversight in the planning and running the College’s main events. This was a role that fitted naturally with Chantelle’s friendly, approachable and hardworking characteristics and she quickly got to grips with a role with increased responsibility.

Over the years Chantelle remained as the Events Supervisor, managing and supporting the events team with her bubbly and friendly style. Chantelle was consistently regarded as a supportive manager who was willing to assist others fulfil their potential as the team grew in size and stature over the next decade.

She was also instrumental in helping to build the College’s events team into an effective and competent education function, able to deliver a broad programme of professional development events across the UK. Chantelle was notably responsible for the development and growth of the Anniversary meeting, helping the College to establish our renowned cadre of regional events and supporting the work of the Education and Nominations Committees — ensuring that those put forward for the College’s most prestigious awards are duly recognised for their commitment and contributions to anaesthesia.

Chantelle also played a key part in many positive changes during her time at the College, including the introduction of the OLS online booking system, the increase in the number of events and the growth of some of the College’s most popular courses such as the Anaesthetists as Educators’ Programme. Chantelle consistently demonstrated a positive outlook to any problem, no matter how big. She was valued highly by staff and clinicians alike and she will be remembered as someone that was never without a smile and always looked out for her team.

Chantelle was caring and kind and enjoyed many close friendships at the College. Such was Chantelle’s popularity that many of her colleagues stayed in touch after they left the College. Chantelle enjoyed dancing and music, and was often the first on the dance floor at our socials. We will miss her laughter and the fun that she always brought with her.

Chantelle will be missed by friends, colleagues and those members that knew her, and her positive outlook and good sense of humour will continue to thrive in the College.

Chantelle’s funeral was held on 4 June 2018.

We will be always grateful for the dedication and contribution that Chantelle made during her long service at the College.
To anaesthetists and critical care physicians, a focus on systems is intuitively reasonable – we work in one of the most complex areas of medicine.

Improving clinical care by thinking in terms of the systems that deliver care, and how they can be re-engineered, is a concept embodied in terms of the systems that deliver improving clinical care by thinking – a pragmatic art marshalling scientific theory which does not help them deliver meaningful change. However, the RAEng report is notable for both its brevity and its clarity, and we would encourage those involved in improvement at any level to read it – particularly the clinical examples referenced within it. Rather than being seen as seeking to burden clinicians with unfamiliar engineering jargon, the report can be read as a simple challenge to conceive improvement projects based on four key questions:

- How have I sought to understand the role of all the people involved in this project?
- How can I understand all of the parts of the system which affect the change I am looking to make?
- What could go wrong, and what can I do about it?
- How can I design my intervention better, based on this knowledge?

None of these are a challenge to our existing improvement efforts – but they may help us to think differently as to how we can continue to improve the quality and safety of the care that we deliver.

References

Supporting colleagues in the aftermath of the Manchester bomb

The night of the bomb, I (Sarah Thornton) went to bed early. I plugged my phone in and, as I did, a notification popped up vaguely describing an incident in Manchester. The following morning my teenage children woke me – did I know about the bombing? I picked up my phone with dread and pride as I saw messages showing how my colleagues had mobilised, rapidly opening four theatres in preparation. Eighteen casualties arrived around 3.00am, all were triaged and sorted by the brilliant emergency department, and went to theatre that day.

Aside from horror, I was swamped with guilt – if I had taken my phone to bed I could have gone in too. I then realised that, as Head of School for the North West, I had a responsibility to care for the carers who had dealt with this and ensure they received support. I quickly discovered I was not alone in these feelings. Along with the Intensive Care Medicine executive and Emergency Medicine Head of School, I organised a regional debrief. This occurred the following week once the injured had been looked after and people had time to begin to process what had happened. We advertised widely, including through social media, and 35 attended including a number of consultants. I had never run a big debrief so did what we all do when lacking information – I asked Google. A few clicks and I found the seven-stage Mitchell model on which I based it.

1 Introduction
I explained the process. I talked about why this event may be different to previous experiences – its nature, concern for the safety of staff (there were reports of gunmen outside some of the hospitals), staff personally knowing people affected, and the fact that it was in their home city.

2 Facts
The consultant covering Children’s A&E that night presented the data for how the work had been shared and patients distributed between different hospitals in the area according to age and severity of injury. He talked about his own experience, and then we split into pairs to do the same before coming back together. There were harrowing stories and lots of tears. While the injuries were shocking, most found the human aspects worse – the lack of time to talk to a mother who had just witnessed the unsuccessful resuscitation of her 18-year-old before the next casualty was wheeled in, the 12-year-old waiting for theatre not knowing that both parents were dead.

3 and 4 Thoughts and Reactions
This was more small-group work, starting with participants’ thoughts, then progressing on to their reactions and drawing out expression of potentially painful feelings. We discussed how they coped: [sleep, exercise, the occasional battle of wine], then moved onto what positives they had found. Apart from their feelings about the incident itself, no one expressed negativity. The major incident plan seemed to have worked well, the staff involved came together and worked in a supportive and constructive manner. Lovely stories – colleagues insisting on covering the subsequent nights for the anaesthetists in training who had been working at the Children’s A&E; Sodexo providing free hot food.

5 Symptoms
The psychologist, John, took over and discussed the impact of previous terror attacks. Apparently, in the days following 9/11, 40% of emergency workers showed signs of PTSD; yet four months later that was 4%. Compulsive watching of television coverage actually made symptoms last longer. He suggested that it can be harder for those feeling helpless at home wanting to help.

6 Teaching
This aims to normalise the symptoms of stress and to provide management techniques. John did this with a series of verbs –

- Accept – that you can’t change what’s happened.
- Connect – with those around you. It’s a chance to rebuild relationships. Discuss feelings to process and normalise them. Acknowledging the trauma you feel helps you deal with it.
- Read – around the subject of what you experienced. Knowing more and being more prepared makes you more confident. If I can deal with that I can deal with anything.

7 Re-entry
I summarised and signposted sources of further support, including sessions with John or myself. These were shared on our Facebook page and website. We concluded with informal chat over cake.

Four months later we organised ‘Wellfest’ – a family event with bouncy castles, stalls, face-painting and live music. We had mentors available and the Manchester Resilience Hub provided counsellors. It has been suggested that resilient individuals are not afraid to seek help. We had no takers for the professional support. Maybe we had done what author Eric Greitens suggests resilient people do and found a healthy way of integrating a hard experience into our lives, or perhaps those that needed it weren’t there. We do, therefore, need to look out for those that may be struggling and remind ourselves it’s okay to not be okay.

References
#AirwayHub: innovating multidisciplinary airway training

Dr Roxaan Jappie, Locum Consultant Anaesthetist, University College London Hospitals (UCLH)
Dr Peter Thomas, ST6 Anaesthesia, North Central School of Anaesthesia

#AirwayHub is an innovative and multidisciplinary educational platform in airway management, which has grown from strength to strength since its inception in January 2017, triggered by the expansion of Head and Neck surgical services at University College London Hospital and the increasing incidence of perioperative airway emergencies.

As highlighted in the Fourth National Audit Project (NAPA)4 inadequate education and training in airway management is the third-greatest contributory factor to major airway complications, after patient factors and poor judgement. #AirwayHub addresses this problem directly through the provision of well-executed regular teaching and training in an inclusive multidisciplinary arena allowing for reflection and discussion, with a special focus on clinical skills, teamwork and communication.

#AirwayHub sessions
Our pan-London region is home to numerous centres of excellence in head and neck anaesthesia, and the #AirwayHub programme benefits from a world-class expert faculty, comprised of specialised clinicians who contribute to the programme design and delivery. The monthly educational sessions are free and open to all. Typically the meeting begins with a set of practical skill stations followed by expert presentations (Table 1). Case reports, morbidity and mortality discussions and quality improvement projects complement the theme of the session. Skills stations include video-laryngoscopy (now universally available in all anaesthetic rooms at UCLH) and fibreoptic-guided intubation simulation. Scalpel cricothyroidotomy, and fibreoptic-guided intubation through a supraglottic airway device using an Airtraq intubation catheter, as recommended by the Difficult Airway Society (DAS 2015 Guidelines2), are demonstrated at every session and are part of our department’s statutory and mandatory two-yearly training for consultant anaesthetists and anaesthetists in training, physicians’ assistants, fellows and specialty doctors.

Free Open Access Medical Education (FOAM)
#AirwayHub meetings are announced through mailing lists and via all five London schools of anaesthesia. By embracing the ethos of Free Open Access Medical Education (FOAM, #FOAMed), which advocates ‘medical education for anyone, anywhere, anytime’, we strive to share and discuss the subject matter with other airway experts and enthusiasts who aren’t physically able to attend the meeting. Via our Twitter handle (@AirwayHub), and using our ‘hashtag’ (#AirwayHub), we provide ‘live’ updates for our worldwide followers, and broadcast the presentations via ‘Periscope’, achieving more than 200 views per broadcast.

Evaluation
With an average of 30 attendees each month, comprising anaesthetists, intensivists, operating department practitioners, paediatricians, critical care nurses, speech and language therapists, physiotherapists and surgeons, #AirwayHub participants report that both the skills training and lectures have improved their knowledge and level of confidence in performing various airway techniques. The availability of a multidisciplinary expert faculty and the provision of a forum for learning and exchange have generated plentiful ideas for projects and innovative collaborations.

#AirwayHub has been particularly successful amongst anaesthetists in training. The informal sessions offer a rich learning environment in which to practice and hone their practical skills under the guidance of expert tutors. The learning objectives are matched to the RCoA syllabus and CPD matrix, and have been allocated RCoA CPD points. The Airway Fellows at UCLH are heavily involved in the design, organisation and delivery of the programme, developing their skills in education, leadership and management.

A glimpse into the future
Since January 2018 we’ve run a pan-London #AirwayHub with a 2ub and spoke format based at UCLH (the ‘hub’) and closely linked to external sites (the ‘spokes’), who host the meeting, generating further networking and the exchange and sharing of best practice. In March, #AirwayHub featured at the South Thames Airway Group meeting, and in April a joint meeting was held at the Royal London Hospital with a special focus on airway trauma.

We present a successful, ultra-accessible and innovative pan-London multidisciplinary educational programme in airway management. The open access multidisciplinary approach offers an ideal forum for discussion and dissemination of best practice, and encourages inter-professional communication and collaboration within the London region and beyond. To find out more about #AirwayHub or if interested in organising a joint meeting in your department, please contact Dr Emilie Hoogenboom, Consultant Anaesthetist, University College London Hospitals (UCLH) or Dr Roxaan Jappie, Locum Consultant Anaesthetist, University College London Hospitals (UCLH).

References

Table 1 Topics covered in #AirwayHub sessions

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I felt a huge amount of guilt about leaving the NHS. However, we both felt it was now or never...
Preoperative anaemia is independently associated with poorer outcomes from surgery. There is good evidence for intervention to correct anaemia prior to major surgery, and it is one of the few preoperative interventions which can improve outcomes. A recent international consensus guideline gives clear advice on how to manage preoperative anaemia.

The prevalence of preoperative anaemia is variously reported around 30 per cent. The prevalence of preoperative anaemia is independently associated with poorer outcomes from surgery. The timeframe in which we are hoping to intervene can also be challenging, particularly in the case of cancer pathways. Currently there is no clear evidence to recommend delaying surgery for several weeks to treat anaemia. Another issue in many of our patients is the pathophysiology of iron metabolism. In chronic inflammation there is up-regulation of hepcidin, which impairs dietary iron uptake and incorporation into haemoglobin. This normally mandates the use of intravenous iron to augment iron stores.

During our many discussions, we arrived at the four key issues in our perioperative anaemia service.

1. How can I set up a pathway to address and treat anaemia as part of our perioperative service?
2. How can we ensure that patients get timely iron treatment?
3. How do I introduce an intravenous iron service? How do I know it is safe? How do I know it is cost effective? Is it already being done elsewhere in the hospital?
4. How do I measure outcomes, and what data should I be collecting?

To address these questions, we ran a workshop aimed at taking delegates through the process of setting up a perioperative anaemia service. It was intended to be a practical ‘how-to’ guide, and was kindly supported by industry. We invited local leads for perioperative medicine to a workshop day at the College. They were also invited to bring up to two multidisciplinary colleagues who they would be working with to set up their service. The key to this event was the involvement of other disciplines and specialties, both in terms of delegates and speakers.

Multidisciplinary talks

- Dr Andrew Klein spoke about the epidemiology of preoperative anaemia, the rationale for treatment, the pathophysiology of iron metabolism, and personal experience of setting up an anaemia service.
- Dr Alwyn Katze offered a practical guide to the diagnosis and management of anaemia.
- Dr Jane Keidan, a haematologist, dispelled a number of myths about intravenous iron, and particularly looked at the long track record of efficacy and safety of intravenous iron in his specialty.
- Dr Matthew Johnson, a gastroenterologist, talked about how to investigate anaemia once it is identified, and talked us through a few tricky cases.
- Dr Kieran McCafferty, a renal physician, talked about the long track record of efficacy and safety of intravenous iron in his specialty.
- Dr Allyn Kotze offered a practical guide to the diagnosis and management of anaemia.

We had afternoon workshops, with additional talks from a pharmacist, anaesthetists and a haematologist who involved with the NICE guidelines on anaemia. The most popular session looked at how to collect, costs, coding, and a worked example. We had excellent feedback and the event was hugely popular, selling out quickly; therefore we are considering running a further event. Please visit the perioperative medicine microsite www.rcoa.ac.uk/perioperativemedicine for more resources on anaemia.

Preoperative anaemia is independently associated with poorer outcomes from surgery. There is good evidence for intervention to correct anaemia prior to major surgery, and it is one of the few preoperative interventions which can improve outcomes. A recent international consensus guideline gives clear advice on how to manage preoperative anaemia.

References

EXAMS MYTH BUSTING

The components of the FRCA examination often involve periods of intense preparation, extreme emotion and ultimately overwhelming elation (for most).1 We know that, despite lots of online resources, the exam process can be a mystery. Using actual questions from anaesthetists in training, we have formatted this article into Q&A style to dispel some of the myths that surround the exam.

Why are they so expensive?

The exam may appear expensive at first sight, but the College does not make a profit from it. At each sitting we have upwards of 55 examiners attending for the week.

In addition there are considerable running costs such as question development, standard setting, training and marking, as well as funding actors and equipment. So overall the resource required to examine many hundreds of candidates is considerable. Further information on the cost of training and exams can be found on the College website (http://bit.ly/2HME06n).

What do examiners actually do during the exam week?

A huge amount. Most examiners spend their time examining candidates. Examiners usually arrive before 8.00 am and the day commonly stretches beyond 6.00 pm.

Senior examiners spend slightly less time examining because they are closely involved with running the exam floor during the week.

We also need to remember that much work is done between exams with question development, question review, and the preparation of multiple choice question (MCQ) and short answer question (SAQ) papers, so the contribution of each examiner is considerable.

How are examiners selected?

Is it true they are largely academics from teaching hospitals?

Not at all. The Board of Examiners represents a cross-section of consultants from around the country who are familiar with the standards required for anaesthetists in training to pass the exam. There is a formal application process for anyone wishing to become an examiner. The selection is based upon demonstration of a sustained commitment to training, assessment and exam preparation. The details and person specification are available on the College website.

How many tend to apply to become examiners, and how do you choose between the applicants?

We generally get 60 to 70 applications per year. Application forms are anonymised and distributed to the exams committee. Each member of the committee scores the applications against the person specification. The number appointed ensures that we can replace retirees and steadily increase overall examiner numbers. Generally we appoint about 15 each year.

It must be difficult starting as an examiner. How do you train them and make sure they perform satisfactorily?

Yes. The first year is undoubtedly challenging. For this reason, we treat it as a probationary year prior to formal election to the Board of Examiners. Examiners elect are invited to observe the May Primary exam to familiarise them on the process. It is then mandatory for each new examiner to attend a training day held at the College in October. This is run by senior examiners, and covers examiner behaviour, standards, expectations and responsibilities.

How do you make sure they perform to an appropriate standard?

All examiners start in the Primary. In the structured oral exams (SOEs); new examiners are paired with an examiner of several years’ experience for their first exam week. This allows for individual mentoring and feedback, as well as an opportunity to discuss and compare marks to aid standard setting.

In addition, during their first year every examiner is videoed and audited by other examiners. This process gathers information about their questioning style, verbal and non-verbal interactions, pace, timing, behaviour, and marking standards. These feed into an end-of-year appraisal where performance is reviewed. Satisfactory completion of the first year results in formal election to the Board of Examiners.

How are new questions set?

All new questions are rigorously reviewed and, for tested before being accepted into the question bank. Every section of both exams has its own examiner working party that regularly reviews questions, introduces new ones, and ensures that all questions are mapped against the curriculum.

But what happens if a question is unfair or too difficult?

We continually review the performance of questions. Each working party will receive the overall performance of candidates on the question in their section after each exam. If a question generates unexpected or atypical outcome data, the question will be removed from the exam and the overall pass mark will be adjusted accordingly so that no candidates are disadvantaged. The overall performance of candidates on each question is recorded in the question bank, which creates a difficulty index for each question, and this is used as part of the question selection process so that exam papers reflect an equal difficulty from sitting to sitting. This is a rigorous process of challenge and review designed to make the exam as fair as possible.

Is there a certain proportion of candidates that have to fail each exam?

No, there is no pass or fail quota. The pass mark for each section of the exam is set using approved standard-setting methods, and each candidate is treated entirely independently against this mark. In theory every candidate could pass (or fail) at any one sitting.

If you have already failed before do the examiners know that next time?

No. Candidates’ identity and previous performance is unknown to examiners.

How have the addition of single best answers [SBAs] into the Primary affected the pass rates?

SBAs were introduced to the Primary in 2011, and since then the pass rate of these questions has consistently exceeded that of the multiple true false questions (MTFs). Over the last four years, the average, nominal pass rate for the MTFs has been around 40%, while the SBAs has been around 70%. This gives an average overall pass rate of around 56%. So contrary to popular belief, the addition of SBAs is in fact helping candidates to pass rather than hindering them.

Reference

Differential pass rates in the FRCA: An Update

The July 2015 Bulletin reported on the thorny issue of differential attainment in the FRCA, presenting data showing that, in common with other specialty exams, some candidate groups perform better than others. The effects of gender, ethnicity, training post and primary medical qualification (PMQ) all affect outcomes.

As part of the College’s commitment to delivering the fairest examination possible, the exams department have undertaken two projects aiming to better inform both candidates and trainers as to how to optimally prepare for the FRCA. Both reports can be accessed online: http://curep/J5yoP8Y.

Differential attainment in curricular components

This project looked at how candidate groups performed in the curricular units tested in Primary and Final FRCA. All questions from four sittings of the oral exams were mapped to the training curriculum then each candidate’s score analysed (more than 20,000 results per exam). Summary findings include the following –

- Anatomy questions in both the Primary and Final examinations were answered better by ethnic minority candidates. This may reflect more thorough undergraduate anatomy teaching in non-UK medical schools.
- Female candidates tended to score higher than males in Primary communication skills and clinical scenarios questions.
- All ethnic groups, including those with a UK PMQ, performed less well than white candidates across most Primary curricular components. This may relate to over-representation of candidates in non-training posts in the ethnic minority group.
- Some groups, eg, those with a European PMQ, received low scores in objective structured clinical examination (OSCE) stations involving simulation, suggesting less experience of simulation-based assessment.
- Differences between group performances in different modules were less in the Final SAQ than in the Final SOE, except for anatomy questions.

- In Finals:
  - Asian candidates did less well in neuroanaesthesia, ICM and obstetrics modules;
  - males did less well in obstetrics (and paediatrics in the SAQ);
  - candidates with a PMQ gained less in the Final SAQ than in the Final SOE.

In three Primary and two Final exams candidates were asked to complete a questionnaire about how they had prepared for the oral examinations. The questions were developed with the College’s Trainee Committee, given to candidates after their exam but before the results were known, and then the responses matched to their overall result for that exam sitting.

Primary candidates completed 563 questionnaires (53% response) and Final candidates 569 (60%). There were small differences in the pass rates of responders versus non-responders in Primary (55% vs. 61%) and Final (68% vs. 60%). Summary findings include the following –

- Study resources used: These were divided into ‘traditional’ or ‘online’ resources. Almost all candidates used traditional resources, and approximately 90% used online resources at their first Primary attempt, though this fell to 80% for subsequent attempts. Use of online resources for Final was lower at 71–77%. For first attempts there was no difference in resources used between pass and fail candidates, but at subsequent attempts for both exams around 10% more of the successful candidates used online resources. There were minimal differences in the resources used between candidate groups.
- Courses: More female than male candidates attended national exam courses, and more Primary candidates who passed both OSCE and SOE together had attended a national course (72.4% vs. 65.7%). Attending regional courses did not seem to confer any advantage at the Primary. For the Final the opposite was observed, with similar attendance rates at national courses for the successful and unsuccessful candidates, while attendance at regional courses was higher in those who passed.
- Study leave and training modules: There were no notable differences in the duration of study leave taken by different groups. In both exams female and white candidates had completed more training modules before sitting the exam but candidates who passed had actually completed less modules than those who failed.
- Exam preparation time: Candidates who passed both components of Primary together had prepared for longer (3.7 vs. 3.2 months), with similar results for Final (4.0 vs. 3.6 months). In both parts of the exam Asian candidates had spent on average 0.4 months less time preparing for the exam. In Primary, successful candidates were more likely to have received exam practice within their department and joined local study groups, but this was not seen in Final.

As with much research, there are no surprise findings in this project: studying for longer and using a range of resources is associated with success. Attending courses and engaging in local exam practice and study groups helps to pass Primary, but these activities are less beneficial for Final. Differences between candidate groups in how they prepared for the exam were small and cannot themselves explain the differential attainment seen.

The College is continuing research to better understand the differences in performance associated with different demographics, and identify the changes that can be made to minimise these.
Inter-agency learning for human-factors training

Dr Heather Gallie
Consultant Anaesthetist and Human Factors Lead, Salford Royal NHS Foundation Trust

Inter-agency learning is a positive, generative and transformative activity with potential to create resilience. The idea for inter-agency learning originated from research into high-reliability organisations. High-reliability organisations have a low accident frequency despite working within narrow margins of safety.1 This low accident frequency results in a paucity of data, so these organisations learn from historical events and other industries to recalibrate their safety perspective.

Human Factors (HF) is the scientific analysis of all the elements that affect performance and therefore contribute to safety, for example, decision-making, teamwork, communication, system and equipment design, and organisational learning.2 HF is ideally suited to inter-agency learning, as it focuses upon the ‘non-technical’ elements common to all. I tested this concept in a pilot study day in 2015.3 In 2016, this was developed into the Human Factors Foundation (HFF) course for fire fighters and healthcare staff. It expanded into HFIC17 – the first inter-agency HF Conference for healthcare, fire service and airport operators, which took place in June 2017. Inter-agency learning removes hierarchy and departmental silos. It opens discussion and creates collaboration between those with experience of HF tools (fire service) and those who are relative novices (healthcare). Feedback from the pilot supports this idea: ‘It was very non-threatening, I found it much easier to speak up’.

The HFIC course required delegates to apply information gained from the course, discuss concepts, reflect on past experience, and share learning. Small, inter-agency groups worked together to analyse historical incidents. Inter-agency learning provided a rich variety of perspectives regarding risk assessment and management. Course feedback supports the benefits of such collaboration: ‘Inter-agency learning was the most refreshing aspect of the course, excellent learning and discussion opportunities, with potential for adopting methodologies between the two industries’.

Another session required delegates to analyse a selection of Standard Operating Procedures (SOPs). This generated discussion about when, why and how SOPs are used. The fire service could illustrate the application of these HF tools to their practice and personal safety. These discussions formed an enhanced reflective practice, and delegates would recall past experiences, using HF theory to describe them. The fire service delegates were often able to recall moments of ‘good practice where things worked well.’

The main benefit of the inter-agency learning was seeing one’s own profession from another’s perspective. ‘Firefighters seem to be well ahead of medicine at present’, and ‘It made me look at my own practice as well as my department’.

This idea of ‘transformative learning’ is supported by research in the social care sector. Every professional group has a set of values, beliefs, norms and behaviours. Inter-agency collaboration removes individuals from these cultural norms. It shows them their profession from another’s perspective, and this transforms their view of their own professional group.4 This has implications for safety. The socialisation that occurs during professional training can result in blindness to institutional and cultural weaknesses, as these are ‘normal’ for all within a particular professional group.5 Inter-agency learning can create awareness of these sources of error.

HFIC17 was attended by 168 delegates, of these, 88 per cent said that inter-agency learning added their understanding of HF and 52 per cent provided a comment that suggested inter-agency learning changed their view of their own profession. Only 14 per cent said ‘No it did not’ (Figure 1).

References

Figure 1 Transformative learning, changing perspective
The first Wednesday of August is a rite of passage for many anaesthetists in training. For some, it is their first day as a junior doctor, when they finally put into practice all the learning of the past years, only to realise (as I did) how very ‘junior’ they still are.

Subsequent Augusts mark a new step forwards in one’s development: new hospital, new role, new level of seniority. By the end you become the ‘old hand’ returning to a hospital you know well, guiding your younger colleagues in their transition.

I became the Old Hand last year. Rather oddly, and for the first time in a decade, I had nothing to do last August. I was no longer a junior doctor, I was not an anaesthetist in training. I was in limbo: taking the leap that all anaesthetists in training must (subject to satisfactory ARCP outcomes and bunging the GMC a wad of cash) eventually take. I was about to become a consultant, or should I say, a junior consultant.

When I started, I certainly felt very junior. But all consultants are equal, which is a strange concept to someone who has existed in a hierarchy of three-digit codes. My new peers hardly feel like my equals: some are twice my age, a couple are members of the most influential councils in our specialty. One is a household name (I think – one’s perceptions of what a household name is gets somewhat skewed when that household contains two anaesthetists and a three-year-old). Most of them have trained me, mentored me, supported me, and helped me get my job.

As a soon-to-be new consultant, I found myself in a dilemma: do I set out to prove myself worthy of my peers, or do I just shut up, keep my head down, and hope no one notices me? The first option may either demonstrate that I was worth all that hard work they’ve put into me, or demonstrate that I’m an annoying upstart who thinks he has all the answers. The second option is just a bit cowardly for my liking.

What complicated things though, was that I became aware there are now many others who might want to scrutinise me: the surgeons, the theatre staff, and now, for the first time in my career, the managers.

You see, as an anaesthetist in training, you are blessed with a clarity of purpose: you exist to do what is best for the patient. I include within that, of course, that training yourself to be the best doctor you can be is ultimately for the patient. What doesn’t really bother you is that the trust you happen to be working in is failing to meet its referral to treatment times, that the four-hour wait is abysmal, and that the finance director has to visit coronary care after every quarterly report is published. These simply aren’t your problems – only the patient is your concern.

From now on though, my loyalty becomes divided. It’s not just to the patient, but to the trust that I work for. I now have to think about how much money I’m wasting and how that patient I want to cancel because the list was meant to finish two hours ago will lose income for my employers. I’ll have to use the cheap old drugs instead of the newer drugs. As an anaesthetist in training I could switch on the Desflurane and think ‘it’s not my problem’. So what do I do? Who should I be trying to impress – my colleagues? My surgeons? My managers? The answer is, of course, obvious – my patients. Yet in a specialty where anaesthetists are barely recognised as doctors by the public, we’re probably the only ones who can really compare ourselves to that holy grail of the airline industry.

This approach means we think differently to our colleagues, and that, being a younger specialty, we’re much less hamstrung by tradition. We adopted quality and safety into our practice well before our peers, and understood the importance of human factors long before others. Of all medical specialties, we’re probably the only ones who can really compare ourselves to that holy grail of the airline industry.

So when it comes to proving myself, I need look no further than the legacy of my specialty – a continual focus on improvement.
High-quality regional teaching has been well established in the Mersey region to prepare anaesthetists in training for the FRCA examinations. Conversely, the regional post-fellowship meetings (PFMs) for post-exam registrars have been unstructured, of variable educational value, and often poorly attended. In this article, we describe the steps that were taken to transform our struggling meetings into high-quality regional teaching days.

Identifying the problems
In order to ascertain the barriers to attendance, an online questionnaire was sent out to all Mersey post-fellowship anaesthetists in training. It became apparent that registrars found it difficult to attend the afternoon half-day sessions due to the location of the meetings (a non-hospital site with limited parking) and failure to obtain release for afternoon teaching. Also, the fixed day of the meetings limited access by registrars on different days of the working week to afford equal opportunity to LTFTs. It was also felt that the educational value of the meetings was much higher. Registrars felt that the meetings were more accessible and sociable, and that the educational value of the meetings was much higher.

Making changes
In response to these barriers to attendance, several steps were taken:

- Meeting locations are rotated around the central hospitals of Merseyside to take advantage of improved facilities and proximity to speakers.
- Study days are rotated through different days of the working week to afford equal opportunity to LTFTs.
- College tutors are encouraged to put PFM dates in departmental diaries so that they can be ‘blocked off’ for teaching.
- PFM dates and programmes are heavily advertised via email and social media.
- Other paperwork
  - Keep a register.
  - Feedback forms – collate feedback and return this to each speaker.
  - Distribute certificates of attendance (consider emailing).

Result
Since the implementation of the new-format PFMs in September 2017, average attendance has risen from 14 to 43 registrars per meeting. This is an increase from 16% to 50% of all Mersey registrars per meeting. Feedback from anaesthetists in training has also been overwhelmingly positive. Registrars felt that the meetings were more accessible and sociable, and that the educational value of the meetings was much higher.

Looking forward
Restructuring the PFMs has removed many of the barriers to attendance and has succeeded in delivering a cost-effective teaching programme. In future, we hope to develop a Mersey PFM website where learning materials can be accessed and educational discussions continued online. We recognise that PFMs are well-placed to provide a platform for discussion of regional quality improvement projects led by anaesthetists in training. We will therefore be working closely with the Mersey Anaesthetic Group for Improving Quality (MAGIC) that oversees such anaesthetists in training collaborations.

Reference

Table 1 Practical tips for organising a teaching day

<table>
<thead>
<tr>
<th>Funding</th>
<th>Consider using the study-leave budget.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Picking a day</td>
<td>Rotate through different days of the working week.</td>
</tr>
<tr>
<td></td>
<td>Cross-check dates against induction days, major meetings, school holidays.</td>
</tr>
<tr>
<td>Picking a location</td>
<td>Pick a central location with ample parking.</td>
</tr>
<tr>
<td></td>
<td>Consider where the majority of speakers are coming from.</td>
</tr>
<tr>
<td>Booking a room</td>
<td>Book rooms early to ensure availability for the dates required.</td>
</tr>
<tr>
<td></td>
<td>Provide details of date, time, equipment needed, number of people expected.</td>
</tr>
<tr>
<td></td>
<td>Request space for catering if providing lunch.</td>
</tr>
<tr>
<td>Catering</td>
<td>Provide refreshments +/- lunch.</td>
</tr>
<tr>
<td>Advertising the day</td>
<td>Ensure dates of meetings are publicised well in advance, encourage early study-leave applications.</td>
</tr>
<tr>
<td></td>
<td>Email College tutors with meeting dates to be marked on departmental diaries.</td>
</tr>
<tr>
<td></td>
<td>Send emails, advertise on social media (eg, Facebook, Twitter).</td>
</tr>
<tr>
<td>Structuring the day</td>
<td>Consider themed days.</td>
</tr>
<tr>
<td></td>
<td>Consultant and anaesthetist-in-training presenters.</td>
</tr>
<tr>
<td></td>
<td>Clinical and non-clinical topics, mapped to higher and advanced training curriculum.</td>
</tr>
<tr>
<td>Picking topics</td>
<td>Examine the RCoA curriculum.</td>
</tr>
<tr>
<td></td>
<td>Identify interesting topics and speakers from conferences, meetings, teaching sessions.</td>
</tr>
<tr>
<td></td>
<td>Consider what is topical.</td>
</tr>
<tr>
<td></td>
<td>Medicolegal topics.</td>
</tr>
<tr>
<td></td>
<td>Career development (eg, consultant interviews, CV building).</td>
</tr>
<tr>
<td></td>
<td>Interesting/difficult cases that anaesthetists in training have experienced and learnt from.</td>
</tr>
<tr>
<td></td>
<td>Volunteering experiences, out-of-programme experiences.</td>
</tr>
<tr>
<td>Contacting your speakers</td>
<td>Contact them early.</td>
</tr>
<tr>
<td></td>
<td>Brief them on what you would like them to speak about, time allocated for them, method of presentation preferred/available.</td>
</tr>
<tr>
<td></td>
<td>Nearer the date, send email reminders with the programme, location (along with a map), time they are expected to arrive.</td>
</tr>
<tr>
<td></td>
<td>Offer reimbursement of travel expenses.</td>
</tr>
<tr>
<td>RCoA CPD accreditation (for meetings involving non-trainees)</td>
<td><a href="http://www.rcoa.ac.uk/regulation-and-code/applications-cpd-approval">www.rcoa.ac.uk/regulation-and-code/applications-cpd-approval</a></td>
</tr>
<tr>
<td></td>
<td>Apply at least six weeks in advance.</td>
</tr>
</tbody>
</table>
Improving anaesthetic training through Cognitive Apprenticeship

Dr Luis Lee
Consultant Anaesthetist, Buckinghamshire Healthcare NHS Trust

Dr Farshad Shaddel, Consultant Psychiatrist, Berkshire Health NHS Foundation Trust

Dr Denis O’Leary, Honorary Clinical Tutor, Medical Sciences Division, University of Oxford

The Cognitive Apprenticeship Model (CAM) lends itself well to postgraduate medical training. It is an educational theory that incorporates consultant supervisor training skills, workplace-based learning and trainee development from novice to expert over the duration of a programme. The model extends the traditional apprenticeship approach through developing trainees’ cognitive training skills and three cognitive skills by the traditional apprenticeship approach through developing trainees’ cognitive training skills and three cognitive skills by

The model defines three apprenticeship training skills and three cognitive skills by which trainers may help trainees to adopt the specific clinical thinking processes underpinning anaesthetic competencies (Table 1). Consequently, anaesthetists in training can build on and use this knowledge to undertake more clinically complex tasks. Previously, CAM has been shown to have utility in medical undergraduate and postgraduate training (psychiatry). It has not been formally considered within postgraduate anaesthesia training. Here, we report on the understanding and experience of anaesthetists in training of the CAM teaching methods to test whether it can guide improvements in postgraduate anaesthesia training.

We adapted a previously-used survey questionnaire specifically for anaesthesia training. Inclusion of the definitions of the CAM components allowed respondents to relate them more accurately to their training experience. Using an online-survey tool, the survey was distributed to the 117 anaesthetists in training in the Oxford School of Anaesthesia. The survey protocol was lodged with the Oxford Clinical Trials and Research Governance Committee.

The survey was completed by 48 (41%) anaesthetists in training, with an equal male to female ratio. These included 11 core, 13 intermediate (ST3–4), and 24 higher (ST5–7) anaesthetists in training. Overall, respondents rated the learning environment and training as enjoyable (92%) and well supported (85%), in line with expectations (91%).

The majority were unfamiliar with the terms used by the CAM to describe trainer skills, apart from the term ‘reflection’. However, after definitions were provided, most (67%) agreed that each trainer skill had contributed positively to their anaesthetic training (Figure 1). Anaesthetists in training were then asked to consider the skills they would like their trainers to use more frequently. An analysis of their responses showed that the preferences for specific trainer skills varied with the seniority of their training grade (Figure 2). Core- and intermediate-level anaesthetists in training preferred that their trainers promote their learning by using both apprenticeship and cognitive training skills; higher level anaesthetists in training expressed a very clear preference for trainers to help them use more cognitive training skills.

We believe that, despite the study’s limitations of a moderate response rate and the restriction to a single training region, two key findings emerge. Firstly, each of the trainer skills defined by the CAM were considered to have made a positive contribution to their training within a training experience and learning environment that was considered positive overall. This provides some construct validity to these definitions, in addition to providing trainers and anaesthetists in training with a language to discuss these skills. Secondly, using the CAM terms for these skills, anaesthetists in training were able to discriminate between the types of skills they wanted trainers to use more frequently to promote their competency development. This finding is in keeping with the model of Cognitive Apprenticeship, with the learner preference shifting towards a greater emphasis on development of cognitive skills with increasing exposure to complex tasks.

In conclusion, we advocate the use of the CAM as a basis for defining trainer skills, for promoting a shared language on trainer skills for trainers and anaesthetists in training, and thus for allowing for differentiation of skills deployment by trainers across training grades and expertise.

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<table>
<thead>
<tr>
<th>Apprenticeship methods</th>
<th>Cognitive methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modelling – trainers actively demonstrating procedures to trainees.</td>
<td>Exploration – trainees actively encouraged to formulate and pursue personal learning goals.</td>
</tr>
<tr>
<td>Scaffolding – trainers providing support to trainees so that they can practise at a higher level than they would have done without this support.</td>
<td>Articulation – trainees explaining their management plan to trainers before executing the plan.</td>
</tr>
</tbody>
</table>

Overall, respondents rated the learning environment and training as enjoyable higher (ST5–7) anaesthetists in training. The majority were unfamiliar with the terms used by the CAM to describe trainer skills, apart from the term ‘reflection’. However, after definitions were provided, most (67%) agreed that each trainer skill had contributed positively to their anaesthetic training (Figure 1). Anaesthetists in training were then asked to consider the skills they would like their trainers to use more frequently. An analysis of their responses showed that the preferences for specific trainer skills varied with the seniority of their training grade (Figure 2). Core- and intermediate-level anaesthetists in training preferred that their trainers promote their learning by using both apprenticeship and cognitive training skills; higher level anaesthetists in training expressed a very clear preference for trainers to help them use more cognitive training skills.

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References


Information governance in context: Technology Strategy Programme

‘Clinical governance’ describes the structures, processes and culture needed to ensure that healthcare organisations can assure the quality of the care they provide and the measures they are taking to continuously improve it. ‘Information governance’ is a framework that supports the management of information and is a key element of the College’s Technology Strategy Programme (TSP).

The TSP is a three-year change programme that will impact on every aspect of the College’s use and procurement of technology. A key driver of the programme is the determination to ensure that College systems are robust and can meet the security challenges of the modern age.

The legal and regulatory environment in healthcare that relates to personal and organisational data is complex. The NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act, and the Human Rights Act are all relevant. The General Data Protection Regulation (GDPR, EU 2016/679) is the next phase in this evolution. It was adopted on 27 April 2016, and became enforceable from 25 May 2018. The GDPR supersedes the Data Protection Act (DPA, 1998), whose Schedule 1 applies to personal data, and condenses the eight principles of the DPA into six principles. The GDPR will be incorporated into the new DPA currently going through Parliament. A data subject’s information must be:

- processed lawfully, fairly and in a transparent manner
- collected for specified, explicit and legitimate purposes, and not further processed in a manner that is incompatible with those purposes
- adequate, relevant and limited to what is necessary in relation to the purposes for which it is processed
- accurate and, where necessary, kept up to date
- kept in a form that permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed
- processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures.

Under the GDPR there are six tests to apply to determine the ‘fairness’ and legal basis for the processing of personal data, at least one of which must be applicable:

- consent
- contractual
- compliance with a legal obligation
- protection of vital interests of a data subject
- public interest or in the exercise of official authority vested in the Controller
- legitimate interests pursued by the Controller or a third party, except where such interests are outweighed by the interests, rights or freedoms of the data subject.

Under GDPR the College is both a data controller and a data processor. The consequences for personal data breaches could be severe:

- monetary fines in two tiers, with the upper tier at up to 4% of global turnover, or £20 million, whichever is the greater
- legal actions (liability for damages)
- reputational damage.

The College has been working over the last 18 months to ensure that our already comprehensive policies meet the requirements of GDPR. This has included reviewing our processes and procedures around key areas such as security and retention of data, subject-access requests and data breaches, and bringing our policies up to date. We have also been reviewing the legal basis for all our processing activities. As part of our programme of work, we have ensured that our staff are up to date on the changes to the law and we have introduced mandatory training sessions.

The document collaboration project is one of the pieces of work being done by TSP to support compliance with the GDPR. If you are involved in working with us for the College, this system will provide a document repository. Many of these documents will contain personal data and so a robust, auditable and secure system is vital to the future functioning of the College. The system will be structured in such a way that GDPR compliance can be assured. Collaborating will be easier, as you will always know that you are looking at the most up-to-date version of the document. Yet GDPR is not the only reason for robust document management. Such a system allows for easier administration, with the system set up to standardise document templates, notifications, audit and versioning. GPAS is an excellent example of the relevance of the document collaboration project. ACSA assessors, and anaesthetic departments can rely on the availability and currency of documents, while being able to easily reference historical documents to review the changes. When the College is subject to audit then such a system can provide detailed reports and all relevant documentation. Although such a system has an administrative overhead, the benefits to the end-users are immeasurable. This is a significant step in the right direction in the management of all College documentation.

If you have any questions about data protection at the RCoA please contact: dpo@rcoa.ac.uk. If you would like to know more about the TSP or document collaboration project please contact TSP@rcoa.ac.uk.

Dr Paul McAndrew
Consultant Anaesthetist and Deputy Medical Director, City Hospitals Sunderland

Sharon Drake
RCoA Deputy CEO and Director of Clinical Quality and Research

If you have any questions about data protection at the RCoA please contact: dpo@rcoa.ac.uk

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Human factors—avoiding a bumpy landing
Musings of a jobbing anaesthetist on the RCoA Council

The drive to understand the role of human factors in the genesis of untoward incidents has brought two ‘natural allies’ – anaesthesia, and the aviation industry – closer together. I have conjured up this image of myself in the cockpit, minus the sartorial elegance, fully focused on the hugely responsible task of safely ‘piloting’ each patient through the (perilous) perioperative period.

Emerging from the wreck, shaken and stirred but mostly intact, I asked myself, ‘What went wrong there?’ And then as the dust settled, I could see the problem clearly. Firstly, there are no airline companies out there that arguably operate anything other than the anaesthetic equivalent of an ASA 1 aircraft – not to mention the suffix ‘E’ after each number! If you know any different, please let me know – I will take flight! Secondly, while it is a case of the pilot and a complex but healthy aeroplane interfacing in the aviation industry, in the anaesthetic realm there are three colliding (and colluding) factors at play: the anaesthetist (of varying experience), a variably (un)healthy patient, and a ‘healthy’ machine. Thirdly, there are two trained pilots on most airborne flights, which contrasts with anaesthetic practice, in which a significant proportion of operating lists are managed, and increasingly so, by a sole operator.

Incident reporting is now an embedded practice in medicine. There isn’t a ‘black box’ equivalent in anaesthetic practice, a standard on all planes. Setting up and operating a national database of untoward events in anaesthesia can prove challenging and very expensive. Our evidence base for preventing and managing adverse incidents accrues from scientific publications, Safe Anaesthesia Liaison Group reports, and local incident reporting mechanisms. These reports constitute just the tip of the iceberg, as vast quantities of vital information that should assist in our understanding of human error is not shared or goes unreported. This is perhaps because many incidents are viewed as too ‘trivial’ to report, or are not reported due to fear of retribution, duty of candour notwithstanding. Unlocking this ‘hidden’ information is a challenge for the specialty.

A collateral effect of the anaesthesia–aviation collaboration is the proliferation of human factor workshops offering simulator-based training to enhance our ‘mindfulness’ skills. Anaesthesia is a craft specialty, and repeated practice can make all the difference. In the current training system, the number of exposures to cases is limited as compared to previous generations of anaesthetists. Simulators may help bridge some of the experience gap. With increasing numbers of more challenging patients being listed to undergo complex surgery, it would also make sense to bring in a formal system of mentors (not unlike educational supervisors) for newly appointed consultants for a period of a few years. This would give our younger colleagues the support they need at this critical stage in their careers.

In the end it is experience, underpinned by science that enables our transition from nervous novices to ‘artful’ anaesthetists. It is experience underpinned by science that enables our transition from nervous novices to ‘artful’ anaesthetists.
A century later, Recent Advances in Spain and Germany.1,2 Ether was first introduced in the US by reports in the mid-nineteenth century. Causes have changed since the earliest operating theatre, but the incidence and explosion risks in 1964.4 By 1993 the explosion rates for ether, ethylene, acetylene, cyclopropane, ethyl chloride, and the anaesthetic ethers, air, oxygen or nitrous oxide acted as oxidising agents. In 1939 in the US, the explosion rates for ether, ethylene and cyclopropane were reported as being between 1 and 4 per 100,000 anaesthetics, with a mortality rate of 1 in 1,150,000.1 These agents were still cited as explosion risks in 1964.4 By 1993 the advice was to avoid flammable agents completely if possible.3

The source of Ignition
In 1948, the possible sources of ignition were listed as static electricity, non-static electricity, sources of heat and spontaneous ignition. Sources of heat included cigarettes, lighted matches, candle flames, hot wires, diathermy, light sources and, when giving anaesthetics in patients’ homes, open fires, gas stoves and electric fires with exposed elements.

While one would hope that cigarettes and naked flames have been removed from this list and anaesthesias are no longer given in patients’ homes, other sources have not changed.

Management of risk
Anti-static precautions
In 1937, the American Society of Anesthesiologists found static electricity to be the dominant source of ignition, and recommended that the humidity in theatres should not be less than 60%, that all operating floors should be anti-static, that all anaesthetic equipment should be made of conductive material, and that all personnel and equipment should be earthed.4 These principles are still the recommendations, but are expensive to implement. Since the early 1990s in the UK, it has been decided only to provide anti-static facilities in new buildings if the anaesthetic department and the health authority agreed that flammable agents might be used.5

Electrical equipment
In 1948 equipment needed to be spark proof and regularly serviced, and electrical sockets more than three feet from the floor to avoid contact with heavy layers of inflammable vapours. Current recommendations, if flammable agents have to be used, are to create a ‘zone of risk’, extending 25 cm from any part of the apparatus or the patient’s airway that contain the anaesthetic mixture, and to exclude any potential source of ignition from this zone.

Diathermy
By the 1960s, diathermy was second to static electricity as a cause of explosions, and the recommendations were either to avoid explosive anaesthetics completely or to stop their administration five minutes before using diathermy, blowing air through the apparatus to remove any residual vapours. Nitrogen or carbon dioxide could be used to wash out ignitable gases in the mouth or deep cavities.4

Today’s challenges
The variety of new agents and anaesthetic techniques have eliminated many of these risks; however, surgical advances have provided new challenges. The introduction of laser surgery creates such an intense source of ignition that rubber, PVC or silicon tracheal tubes and drapes can all act as fuel. Current recommendations include the use of flexible metal or metallic-coated tubes and the filling of the cuffs with saline. Alternatives are the avoidance of tracheal intubation and the use of insufflation, injector techniques or high-frequency ventilation. Oxygen concentration should be kept below 30% where possible, and intermittent flushing with 100% nitrogen still has its place.

Both are recognised hazards in the operating theatre, but the incidence and cause have changed since the earliest reports in the mid-nineteenth century. Ether was first introduced in the US by Morton in 1846, and by 1847 reports of such events occurred in both the popular and the medical press as far away as Spain and Germany.1,2

A century later, Recent Advances in Anaesthesia 1 included a chapter on ‘The Explosion Risk of Anaesthesia’, driven by the increased trend for surgeons to use ‘electrical and other apparatus using heat’. In 1948 in Great Britain, there were approximately 100 cases of burns of the heat’. In 1948 in Great Britain, there were approximately 100 cases of burns of the airway that contain the anaesthetic mixture, with a mortality rate of 1 in 1,150,000.1 These agents were still cited as explosion risks in 1964.4 By 1993 the concept of a ‘fire triad’ comprising an ignition source, fuel, and an oxidising agent is well known. An explosion is defined as a sudden, loud and violent release of energy.

AS WE WERE...
Fires and explosions

Dr Anne Thornberry
Chair, RCoA Heritage Committee

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References
1. Fires and explosions – M Grant. Correspondence. BJA 1959;75 666-669.

In 1948, there were approximately 100 cases of burns from ether explosions.

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

RCoA Small Research, Education and Travel Grants

The National Institute of Academic Anaesthesia has several small grants funded by the College for the purpose of supporting research, education or travel connected with the study of anaesthesia. Priority will be given to educational projects, the presentation of original work or the provision of education to developing countries. Applications are invited for the following funds:

Ernest Leach Research Fund
This fund was established in June 2011 to be utilised for the purposes of research. Value up to £2,500 per grant

Sargent Fund
For education and research purposes. Value up to £2,500 per grant

Belfast Fund
To fund grants for educational purposes. Value up to £600 per grant

Eligibility
All College members and fellows in good standing, and registered anaesthetists in training, are eligible to apply for the above grants. We regret that applications for funding towards registration for higher degrees or college course fees will not be considered.

To apply
Please visit bit.ly/2F52Z7U to view the assessment criteria and download a copy of the application form, which must be emailed to the NIAA Coordinator at the address below. The deadline for applications is 5.00pm on Friday 7 September 2018.

Payne Stafford Tan Award – An Award for Clinical Excellence
This award was originally established through the generosity of an American friend of the College, Mr Norman Knight. The aim of the prize is to mark excellence in clinical practice, teaching or research in anaesthesia, critical care or pain management. The award is open to any fellow or member of the College, and comprises a grant (to a maximum of £1,000) to be used for educational purposes such as attendance at a major conference or the purchase of educational materials. The recipient will be expected to provide a short report outlining how the funds have been used.

To apply
Nominations are now invited for the 2018 award, and must be made by a fellow or member of the College. The nomination should be in the form of a letter outlining the particular merits of the individual nominated, and should be accompanied by a full curriculum vitae for that individual. Self-nominations are also permitted. Nominations should be emailed to the NIAA Coordinator at the College by 5.00pm on Friday 7 September 2018.

Macintosh Professorship
The College has established a number of initiatives to foster research in anaesthesia, critical care and pain management. Their aim is to encourage experienced researchers, as well as those who are in the early stages of developing a research portfolio. Macintosh Professorships are aimed at established clinical or laboratory researchers who are already performing at a high level. Their purpose is to recognise and disseminate the work of the award holders and facilitate their progress in the academic world.

Recipients of the award will have a national or international reputation in their field. Their curriculum vitae will be consistent with an individual who is performing at, or is on the cusp of, professional level through research, innovation, and leadership. Those who show equivalent excellence in teaching and education will also be eligible for the award.

Macintosh Professorships are awarded for one year (normally the academic year). Recipients are required, within that time or soon after, to give a keynote lecture at a meeting organised by the RCoA or its associated Faculties, other related organisations and specialist societies. The lecture is commemorated by the presentation of a certificate.

Applications for Macintosh Professorships are open to members of the College and other clinicians and scientists involved in anaesthesia, critical care and pain management within the UK. Applications will be considered by the board of the NIAA and expert external advisors.

The College welcomes nominations from national and/or specialist societies in anaesthesia within the UK. If successful, the title of the Professorship will reflect a joint award from the College and nominating body.

To apply
Please submit a synopsis of your proposed lecture, along with a curriculum vitae and covering letter by email to the NIAA Coordinator at the College by 5.00pm on Friday 7 September 2018.

Maurice P Hudson Prize
Dr Maurice Hudson was a consultant anaesthetist in London, took the DA in 1936, was awarded the FFARCS in 1948 and had a particular interest in dental anaesthesia. The Hudson Harness was one of his innovations.

The late Dr Maurice Hudson’s daughter generously donated money to the College in memory of her father for an annual prize for the best paper on his favourite subject; resuscitation.

The criteria for this prize have now been extended and the prize will be awarded to the anaesthetist in training or intensive care trainee who is the principal author of the best paper relating to the management of acutely ill patients published, or accepted for publication, in a peer-reviewed journal.

To apply
If you are such a trainee and have published an article since 1 August 2017, please submit your article along with a copy of your curriculum vitae and a covering letter by email to the NIAA Coordinator at the College by 5.00pm on Friday 7 September 2018. A prize of £500 is available.

Please note that only one article may be submitted per applicant.

Applications for the above grants, awards and prizes should be sent to the NIAA Coordinator, Ms Pamela Hines, by email to phines@rcoa.ac.uk.

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Applications for the above grants, awards and prizes should be sent to the NIAA Coordinator, Ms Pamela Hines, by email to phines@rcoa.ac.uk.
Association of frailty with failure to rescue after low-risk and high-risk inpatient surgery

This retrospective cohort study looked at patients undergoing inpatient surgery over a seven-year period through the American College of Surgeons National Surgical Quality Improvement Programme (NSQIP) database. It included 984,550 patients from 600 hospitals, grouped according to frailty as assessed using the Risk Analysis Index (RAI). The incidence of any complication was found to be 9.8% in the lowest-frailty group, compared to 58.9% in the highest-frailty group. Failure to rescue (FTR) was defined as death after a serious, potentially preventable complication. FTR increased with the number of complications, as well as with an increasing RAI score. Overall, frailty was shown to have a ‘dose-response’ association with a number of complications as well as FTR in both low- and high-risk operations. The authors close by concluding that frailty is associated with poor surgical outcomes, and so should be incorporated into risk calculations.

Shah et al. JAMA Surgery. 2018;204.

Perioperative acute kidney injury: an under-recognised problem

This review article thoroughly summarises the evidence base and recent developments in the understanding of perioperative acute kidney injury (AKI). It begins by noting that even a trivial acute rise in serum creatinine concentration can result in short- and long-term complications, and may never recover to baseline. The estimated incidence of AKI amongst inpatients increased from 7.2% in 2002 to 20%, in 2012, with around 40%, occurring after surgery and a mortality rate as high as 46%. The cause of perioperative AKI is multifactorial, with hypoperfusion and inflammation identified as the major contributory factors. While surgery type influences AKI to some degree, patient factors show the strongest association, with older, obese females being at highest risk. As serum creatinine only starts to rise after 50% of renal mass is compromised, biomarkers released with renal tubule stress are showing promise for use in the future for early detection of AKI.

Meenatchi M et al. Anesthesiology & Analgesia 2017;125(4):1223-1232

The enhanced recovery after surgery (ERAS) Greenie Board: a Navy-inspired quality improvement tool

This Australian team created a visual feedback system, adapted from a system employed by the US Navy, with the aim of improving compliance with the ERAS protocol among anaesthetists. They undertook a 12-month prospective audit of anaesthetists’ compliance with the ERAS protocol before and after introduction of the new tool. 194 patients were observed in total, and their adherence to the ERAS elements was then displayed in a theatre on a ‘Greenie board’, having been scored by colour coding. Adherence improved, with ‘Green’ (acceptable compliance) increasing from 33% to 72% of patients; p = 0.0001. Anti-emetic prophylaxis improved most (49% to 70%, p = 0.004) with a reduction in postoperative nausea and vomiting (OR 0.42, 95% CI 0.19-0.88; p = 0.023). There was no decrease in other postoperative complications or hospital length of stay.

Smit et al. Anaesthesia 2018;73(6)

Effect of goal-directed haemodynamic therapy on postoperative complications in low- moderate risk surgical patients: a multicentre randomised controlled trial (FEDORA trial)

This Spanish randomised controlled trial included 420 patients, ASA 1 to 3, who were having major elective surgery in five centres. The experimental arm received goal-directed haemodynamic therapy (GDHT) using oesophageal Doppler, while the control arm received standard management by the anaesthetist without cardiac output monitoring. They looked at complications in the 180 days following surgery, including those occurring after discharge. Overall, there was a significant reduction in moderate–severe complications within the GDHT group compared with the control group (8.6% vs 16.6%; p = 0.018). There was a reduction in length of hospital and intensive care stay, as well as reduction in time to oral intake tolerance and ambulance in the GDHT group, but no difference in mortality. They concluded that using GDHT-guided care in patients undergoing major elective surgery may provide benefit.

Cabezudo-Moreno et al. Anaesthesia 2018;73(11).

At a meeting of Council held on 11 May 2018, the following appointments/re-appointments were approved (re-appointments marked with an asterisk).

Regional Advisors

Anasthesia

North West
Dr S Maguire (University Hospital of South Manchester) in succession to Dr R Perkins as the RAA for North West

Imperial
Dr R Bacon (Hammersmith Hospital) in succession to Dr M Hayes

Defence
Colonel G Nordmann to succeed

Regional Advisors

Anasthesia

North West
Dr S Maguire (University Hospital of South Manchester) in succession to Dr R Perkins as the RAA for North West

Imperial
Dr R Bacon (Hammersmith Hospital) in succession to Dr M Hayes

Defence
Colonel G Nordmann to succeed

College Tutors

Wales
*Dr E Curtis (Nevill Hall Hospital)

Scotland
East of Scotland
Dr P Bettes (Ninewells Hospital and Medical School) in succession to Dr C J Weir

Imperial
Dr G Campbell (Ninewells Hospital and Medical School) in succession to Dr M K Mackenzie

East Midlands
Dr N Cooper (University Hospital Nottingham) in succession to Dr C Gormall

NEW TO THE COLLEGE

Regional Advisors

Anasthesia

North West
Dr S Maguire (University Hospital of South Manchester) in succession to Dr R Perkins as the RAA for North West

Imperial
Dr R Bacon (Hammersmith Hospital) in succession to Dr M Hayes

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Imperial
Dr G Campbell (Ninewells Hospital and Medical School) in succession to Dr C L Beecroft

East Midlands
Dr N Cooper (University Hospital Nottingham) in succession to Dr C Gormall

At a meeting of Council held on 11 May 2018, the following appointments/re-appointments were approved (re-appointments marked with an asterisk).
**North West**
Dr Melissa Dransfield
Dr John Porter Joint ICM
Imperial
London
Dr Alice Green
Dr Seema Pai
Kent, Surrey & Sussex
Dr David Hewson
Dr Karuna Ferdinand
Dr Ralph Jepson
East Midlands
Dr Richard Haddon
Dr Thaamharah Mahendrayogam
Dr Kavitha Kuntumalla
Dr Laura Kessack
Dr Helena Stafford
Dr Jaspreet Sidana
Dr Ping Chen
East of England
Intensive Care Medicine or Pre-Hospital
below, who have satisfactorily completed
the GMC for approval, that CCTs/
Training
Certificate of Completion of
Ireland in succession to Dr S-A Phillips
Head of School
succession to Dr S Plastow
Dr C Streets (North Bristol Trust) in
Severn
South West
Dr K Palmer
Chest Hospital) in succession to
Dr N Coulson (Liverpool Heart and
Aintree) in succession to
Dr M J McGovern (University Hospital
Mersey
West Yorkshire
Dr Rachel Asghar
Dr Luke Bishop
Dr Manalisa Marbanian
Dr Michael Munro
Dr Daniel Smith
Dr Hao Tan
Yorkshire & The Humber
Dr Anil Karmali
Dr Adam Spong
Dr Tamara Banerjee
North Central London
Dr Khurram Ayub
Dr Tejal Dave
Dr Bonnie Kyle
Dr Prashanth Nandhabalan
Barts & The London
Dr Lera Al-Shammary
Dr Rupinder Pal Kaur
Dr Kavita Upadhyaya
Dr Dave Mela
Dr Janis Fens
Dr Bradley Lewinsahnh
Dr Simon Matthews
Dr Ee Soo
Dr Naomi Pritchard
Dr Fiona Yu
South East
Dr Michael Adam
Dr Akhil Gupta
Dr Rachel Kool
Dr Min Liu
Dr Louisa Christon
St George’s
Dr Laura Lister
Dr Chris Oscier
Dr Sambath Maitha
Dr Geeta Aggarwal
North West
Dr John MacDonald
Dr Geoffrey Kinsella
Dr Jayasheer Rajeopalan
Mersey
Dr Nick Lown
Northern
Dr Adelade Odubiyi
Dr Rachael Bird
Dr Camilla Waugh
Dr Suresh Narayanan
Dr Girish Rangaswamy
Northern Ireland
Dr Grainne Fitzpatrick
Dr Patrick McAteer
Oxford
Dr Richard Siviter
Dr Lance Holman
Scotland
East of Scotland
Dr Lynsey Paudls
North of Scotland
Dr Callum Kay
South East Scotland
Dr Elspeth Hulse
Dr Elise Hindle
West of Scotland
Dr Ken Wei Tan
Dr Julie Campbell
Dr Laura Jack
South West
Peninsula
Dr Thomas Bradley
Severn
Dr Wanic Pachucki
Dr Hannah Williams
Dr Lara Herbert
Wales
Dr Gordon Leslie
Dr Cen Brynon
Dr Helen Podfield
Wessex
Dr Richard Bolton
Dr Benjamin Hans
Dr Clare Gregory
Dr Kathenne Walker
Dr Hannah McPhee
West Midlands
Birmingham
Dr Imreet Banga
Dr James Cueli
Dr James Westwood
Stoke
Dr Venu Mehta
Dr Thomas Chapman

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**FRCA Examinerships for academic year 2019–2020**

The College invites applications for vacancies to the Board of Examiners in the Fellowship of the Royal College of Anaesthetists, for the academic year 2019–2020. Examiners will be recruited to the Primary examination in the first instance. The number of Examiners required will reflect the number of retirements from the current Board of Examiners.

Applicants shall be assessed against a comprehensive Person Specification, which, along with the Job Description and applications form for this role can be downloaded from the examination pages of the College website: [http://bit.ly/rcoa-examiner](http://bit.ly/rcoa-examiner)

An outline of key essential requirements for the role of FRCA Examiner, which must be met at the time of application, are set out below (although applicants must read the person specification and job description before applying):

**Essential**
1. Fellow by Examination, a Fellow ad eundem, or a Fellow by election of the Royal College of Anaesthetists.
2. In good standing with the College
3. Holds full registration, without limitation, with the GMC
4. At least five years-experience as a substantive Consultant/SAS grade
5. Shall currently be active in clinical practice in the NHS
6. On 1 September 2018 shall have the expectation of completing at least 10 years as an FRCA examiner
7. Can demonstrate active involvement in the training and assessment of trainees.
8. Good written and verbal communication skills
9. Ability to work as part of a team
10. Documentary evidence of satisfactory completion of Equal Opportunities training in the last three years and willingness to undertake further exam specific E&D training on an annual basis.
11. Able to commit to long-term and active involvement to examiner duties including the ability to devote 11 days or more per academic year to the role. This includes both the delivery and development of the examinations
12. Within the past five years shall have visited a Primary or Final FRCA examination.

**Desirable**
Shall demonstrate a special interest(s) directly relevant to the balance of expertise required in the Board of Examiners.

Copies of the person specification, job description and application form can also be obtained by contacting Mr Graham Clissett, Education, Training and Examinations Directorate by Tel: 020 7092 1521 or Email: gclissett@rcoa.ac.uk.

**The Closing Date for Receipt of Completed Application Forms**
IS: MONDAY, 8 OCTOBER 2018.
DEATHS
With regret, we record the death of those listed below.

Dr Michelle Absalom, Wales
Professor Arumugam Ganendran, Australia
Dr Janos Karovits, Budapest
Dr William Mair, Scotland
Dr Kwamena Kyei-Mensah, London
Professor Michael Rosen, Wales
Dr Robert Ware, Wales
Dr Amanda Webster, Dorset
Dr Catherine Wisely, Edinburgh

Please submit obituaries of no more than 500 words, with a photo if desired, of fellows, members or trainees to: website@rcoa.ac.uk. All obituaries received will be published on the RCoA website (www.rcoa.ac.uk/obituaries).

APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS
The College congratulates the following fellows on their consultant appointments:

Dr Jennifer Briggs, Leicester Royal Infirmary, University Hospitals of Leicester NHS Trust
Dr Jing Chen, Queen Elizabeth Hospital King’s Lynn
Dr John Coombes, East Kent Hospitals Trust
Dr Laura Kessack, Cambridge University Hospitals NHS Foundation Trust
Dr Mariya Paschuk, Gloucestershire Hospitals NHS Foundation Trust
Dr Rami Santrupala, Guy’s and St Thomas’ Hospital
Ross Vastronne, Derriford Hospital, Plymouth

APPOINTMENT OF MEMBERS, ASSOCIATE MEMBERS AND ASSOCIATE FELLOWS

Fellows ad eundem:
Dr Richard Land FRCA
Dr Peter Merjavy FRCA

Associate Fellows:
Dr Anand Kumar
Dr Raj Chavan
Dr Mohammed Abdallah

Members:
Dr Bashir Ahmed Thamer
Dr Aled Rhy Morgan

Affiliate:
Mr Gavin Pickard
### MSA SAQ WRITERS CLUB

The Writers Club has seen more than 900+ 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.

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- Timed Practice** in the Mersey Method of Answering SAQs
- Free Admission to the SAQ Weekend Courses
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Writers Club Motto: "Within the Disciplines, Lies the Reward"

Candidates are urged to
Join before September 2018 for the Spring 2019 Examination to reap Maximum Benefit

Enquiries to: writersclub.msa@gmail.com

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#### 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/MCQ</td>
<td>19 – 25 July</td>
<td>No Limit</td>
</tr>
<tr>
<td>Primary OSCE Weekend</td>
<td>12 – 14 October</td>
<td>48</td>
</tr>
<tr>
<td>Primary Viva Weekend</td>
<td>19 – 21 October</td>
<td>No Limit</td>
</tr>
<tr>
<td>Primary OSCE/Orals</td>
<td>26 Oct – 2 November</td>
<td>48</td>
</tr>
<tr>
<td>Final Written ‘Booker’</td>
<td>12 – 16 August</td>
<td>90</td>
</tr>
<tr>
<td>Final SBA/MCQ</td>
<td>17 – 23 August</td>
<td>No Limit</td>
</tr>
<tr>
<td>Final SAQ Weekend</td>
<td>24 – 26 August</td>
<td>No Limit</td>
</tr>
<tr>
<td>Final Viva Revision</td>
<td>20 – 25 October</td>
<td>No Limit</td>
</tr>
<tr>
<td>Final Viva Weekend</td>
<td>23 – 25 November</td>
<td>100</td>
</tr>
</tbody>
</table>

**Booker Course February 2018 Feedback**

- Thank you very much... it has been intense, but I think it’s valuable!
- Really good, I like how the speakers identified previous SAQs on their topic and covered them on the presentation. Able to try different methods for answering questions.
- Thank you, really found course useful.
- Really useful and enjoyable, definitely a benefit of marking and commenting on others’ answers.
- Excellent week, great speakers, a lot of information.
- Exact guide to preparation required at this point in time. Thank you very much.
- The best course I have attended so far!
- Overall the presentations have been of a very high standard.
- Excellent course, Good mix of exam practice and lectures.
- Excellent practice sessions for SAQs.
- All very good lecturers and lecturers.

To see Details of all of our Courses please visit: [www.msoa.org.uk](http://www.msoa.org.uk)

*enquiries@msoa.org.uk*

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### Dingle 20

**20th ANNUAL CONGRESS 1999-2018**

**20th Dingle Congress: Current Controversies in Anaesthesia and Peri-Operative Medicine**

Dingle, County Kerry, Ireland

**Monday 8th to Friday 12th October 2018**

8th – 11th October – UCL & Southampton 20th Ann Annual Congress
12th October – ICSI & SIAA Joint Annual Congress

Call for Abstracts: €1000 in Prizes – Deadline 20th July

**Key Speaker’s include:**

- Mark Edwards - Southampton, UK
- Anna Batchelor - Newcastle, UK
- Toby Reiche - Seattle, USA
- Jonathan Bisset - London
- Denny Lovett - Southampton
- Ramesh Mudigere - Mark Hamilton - London
- Monty Mythen - London
- Mike Grocott - Southampton
- Ross Kerndoe - Newcastle, UK
- Natasha Curry - London
- Wiki Mitchell - London

---

**New Form: Mon-Fri**

**www.ebpom.org**
Working in small groups of five you will cover: the operating theatre, post-intubation period in an emergency situation outside and attitudes required to safely manage the airway and Our simulator-based course provides the knowledge, skills 8–9 November 2018 29–30 October 2018 consultants. Airway Workshop 15 January 2019 Our Airway Workshops provide an opportunity to learn core airway management techniques from experienced consultants.

**UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE**

29–30 October 2018 | RCオA, London 8–9 November 2018 | Edinburgh Royal Infirmary 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. Working in small groups of five you will cover:  ■ difficult and failed airway  ■ paediatrics  ■ post intubation  ■ surgical airway skills  ■ human factors in airway management. “All ran to the highest standard. Very high fidelity. Exceptional teaching and learning” Delegate from Bath June 2017

**LEADERSHIP AND MANAGEMENT**

These interactive workshops offer a balance of plenary sessions, group work and exercises with emphasis on real life issues, open and one-to-one discussions to help you become an better leader in your management role.

**Personal Effectiveness** 21 September 2018 | RCオA, London Gain insight into your own and others’ behavioural preferences and discover how this can impact on your working relationship and role.

**Introduction to Leadership and Management: The Essentials** 25–26 September 2018 | RCオA, London 13–14 March 2019 | RCオA, London Understand how you can improve and use your existing skills to increase your impact and effectiveness within your teams.

**Working Well in Teams and Making an Impact** 14 November 2018 | RCオA, London Enhance your understanding of how teams work through the introduction of tools and frameworks that can be applied to your own team.

“An excellent interactive course with plenty of valuable information for daily clinical practice” Delegate from Harlow | March 2018

**ANAESTHETISTS AS EDUCATORS**

Our series of Anaesthetists as Educators events support clinical educators in delivering high quality training and education in the workplace. Participation in the courses provides supporting evidence towards the GMC approval process for trainers.

**Anaesthetists as Educators: Simulation Unplugged** 3 October 2018 | RCオA, London Equip yourself with the knowledge and skills to develop as simulation-based educators. This course debunks simulation myths and gets back to the nuts and bolts of what you and your learners need.

**Anaesthetists as Educators: Teaching and Training in the Workplace** 8–9 October 2018 | RCオA, London A highly interactive workshop looking at the education and assessment of anaesthetists in training and raises awareness of some of the key concepts associated with education.

**Anaesthetists as Educators: an Introduction** 31 October 2018 | RCオA, London An introduction to postgraduate medical education in anaesthesia, using real-life experiences and interactive workshops. Suitable for trainees, SAS doctors and consultants with no previous training in teaching or medical education.

**ANALYSTS AS EDUCATORS**

Our series of Anaesthetists as Educators events support clinical educators in delivering high quality training and education in the workplace. Participation in the courses provides supporting evidence towards the GMC approval process for trainers.

**Anaesthetists as Educators: Simulation Unplugged** 3 October 2018 | RCオA, London Equip yourself with the knowledge and skills to develop as simulation-based educators. This course debunks simulation myths and gets back to the nuts and bolts of what you and your learners need.

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**Anaesthetists as Educators: an Introduction** 31 October 2018 | RCオA, London An introduction to postgraduate medical education in anaesthesia, using real-life experiences and interactive workshops. Suitable for trainees, SAS doctors and consultants with no previous training in teaching or medical education.

**WINTER SYMPOSIUM**

12–13 December 2018 | RCオA, London Our Winter Symposium brings together world class speakers for two days of thought provoking and engaging topics from across anaesthesia. This event will provide you with information for your own personal development, offering you the chance to learn from and interact with the experts, whilst you network with delegates from all areas of the profession. You will gain valuable insights into the cutting edge of the specialty, through succinct, punchy presentations, that will help you improve patient outcomes.

Last year’s event sold out, and with limited availability. Book now to avoid disappointment.

Delegate feedback from our sell-out Winter Symposium 2017  “Excellent overview of evolving ideas in many fields of anaesthesia” Delegate from the Royal Marsden Hospital, London  “High-quality CPD” Delegate from Papworth Hospital, Cambridge  “Good value for money” Delegate from Princess Alexandra Hospital, Harlow
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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). Hear from the experts about the latest updates in areas of practice you may be exposed to regularly or only occasionally.

**Key topics include:**

- major trauma
- quality improvement
- intubating the unstable cervical spine
- paediatric emergencies
- intraoperative oliguria
- regional anaesthesia
- day surgery
- human factors and resilience
- getting it right first time
- prehabilitation
- gabapentinoids.

**Feedback from our recent sell-out events:**

‘Great value for money update, basically all my external CPD in three days!’
Delegate from Salford Royal Hospital | Updates Cardiff, December 2017

‘Excellent, extremely useful for its practical approach to anaesthetic problems’
Delegate from Moorfields Eye Hospital | Updates London, February 2018

‘Convenient, good value for money, relevant and interesting’
Delegate from South Glamorgan | Updates Cardiff, December 2017