Airway management and training
<table>
<thead>
<tr>
<th>EVENTS CALENDAR</th>
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| Further information about all of our events can be found on our website.  
www.rcoa.ac.uk/events  
@RCoANews |

<table>
<thead>
<tr>
<th>SEPTEMBER</th>
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| **Advanced Airway Workshop**  
18 September 2018  
RCoA, London |
| **Leadership and Management: Personal Effectiveness**  
21 September 2018  
RCoA, London |
| **Developing World Anaesthesia**  
24 September 2018  
RCoA, London |
| **FiCM Preparatory Course**  
24–25 September 2018  
The Studio, Leeds |
| **Introduction to Leadership and Management: The Essentials**  
25–26 September 2018  
RCoA, London |

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<tr>
<th>OCTOBER</th>
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| **GasAgain**  
2 October 2018  
RCoA, London |
| **Anaesthetists as Educators: Simulation Unplugged**  
3 October 2018  
RCoA, London |
| **Anaesthetists as Educators: Teaching and Training in the Workplace**  
8–9 October 2018  
RCoA, London |

<table>
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<tr>
<th>NOVEMBER</th>
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| **UK Training in Emergency Airway Management (TEAM)**  
8–9 November 2018  
RCoA, London |
| **Leadership and Management: Working Well in Teams and Making an Impact**  
14 November 2018  
RCoA, London |

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<tr>
<th>DECEMBER</th>
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| **Winter Symposium**  
12–13 December 2018  
RCoA, London |

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<th>JANUARY</th>
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| **Tracheostomy Masterclass**  
11 January 2019  
RCoA, London |
| **Primary FRCA Masterclass**  
15–18 January 2019  
RCoA, London |
| **Airway Workshop**  
15 January 2019  
RCoA, London |

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<tr>
<th>FEBRUARY</th>
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| **Ultrasound Workshop**  
23 November 2018  
RCoA, London |
| **Anaesthetists as Educators: ANTS**  
26 November 2018  
RCoA, London |
| **Faculty of Pain Medicine 11th Annual Meeting: Topical Issues in Pain**  
30 November 2018  
RCoA, London |

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<th>MARCH</th>
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| **After the Final FRCA: Training years 5–7**  
6 March 2019  
RCoA, London |
| **Ultrasound Workshop**  
19 March 2019  
RCoA, London |

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<tr>
<th>MARCH</th>
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| **Cardiac Disease Symposium**  
3–4 April 2019  
RCoA, London |
| **GasAgain**  
25 April 2019  
RCoA, London |
| **Developing World Anaesthesia**  
29 April 2019  
RCoA, London |

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<tr>
<th>APRIL</th>
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| **Anaesthetists as Educators: Teaching and Training in the Workplace**  
30 April – 1 May 2019  
RCoA, London |

<table>
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<tr>
<th>MAY</th>
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| **Introduction to Leadership and Management: The Essentials**  
2–3 May 2019  
RCoA, London |
| **Anaesthetists as Educators: Anaesthetists’ Non-Technical Skills (ANTS)**  
8 May 2019 |
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Airway training

Dr Will Harrop-Griffiths extols the virtues of a ‘back to basics’ approach to airway training

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An update on the development of an anaesthetic Quality Network

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Implementing improvement science in a hospital setting

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Guidelines and merits of using this novel airway management technique

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The autistic anaesthetic trainee: a personal perspective

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Human factors: the sky’s the limit

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Contents
I am passionate about the NHS. Having worked in other healthcare systems, I believe that the NHS is very special. Through all its challenges, it allows us, as clinicians, to focus on doing what we love: delivering the highest quality of care for our patients. As President, I will bring a combination of clinical, academic and leadership experience to serve, support and lead our specialty. I want the College to facilitate a professional setting that allows all of you to deliver excellent patient care in a supportive and rewarding environment.

This edition of the Bulletin highlights a significant change within President’s office. A big thank you to Council for electing me President. It is indeed an honour and I am truly humbled by the support I have received from colleagues both in and out of the College.

For those members who don’t yet know me, I am an academic consultant anaesthetist in Nottingham since 1994, and have held numerous board and committee roles within the College. I remember fondly when in 2001 I started my formal involvement with the College as College Examiner. It has been a pleasure to contribute in so many ways to the specialty and to meet some wonderful people along the way. I am honoured to be serving the College for the next three years through what will undoubtedly be an interesting time, uncertain period, but also a time that presents opportunity.

I am pleased to be supported by Dr Janice Fazakerley, from the Warrington Mersey region, who was re-elected as Vice President for her second year, and by Dr Simon Fletcher from Norwich, who’s serving his first term as Vice President. Congratulations to both Janice and Simon who bring vast experience, clarity of thought and dedication to their roles. It is also an honour to work with our Council whose members boast immense talent, intellect and drive. Importantly, I will continue to value the support and direction delivered by our CEO Tom Grinyer, his Senior Management Team and our very able and committed College staff. Together, I know we are all dedicated to ensure that the College excels in delivering the objectives of our Charter, and in supporting you, our members, in any way we can.

I’d like to take this opportunity to pay tribute to Dr Liam Brennan as our outgoing President, who has been a great leader and colleague who I’ve worked closely with over the past two years. Liam’s strong work ethic, approachable personality and his dedication to the specialty have been instrumental in modernising the College, its governance and enhancing our impact, both nationally and internationally.
I want to make sure that the College’s expertise helps shape and define reform that improves patient outcomes and the wellbeing and satisfaction of staff delivering patient care.

Way Forward

Strong Governance

The College has restructured its various committees and reporting mechanisms. The College’s work is now governed by four directorate boards: Education, Training and Examinations, Clinical Quality and Research, Communications and External Affairs, and Finance and Resources. These boards report to Council and the newly constituted Board of Trustees. The Board of Trustees benefits from input from voluntary trustees who bring valuable expertise to the College in areas such as governance, finance, law, communications and policy. Over the next one-to-two years, it will be important to ensure that these new governance arrangements are embedded nicely within the College to ensure they deliver the expected improvements in governance, transparency and efficiency.

Education, Training and Examinations

In addition to the ongoing excellent work of the Education, Training and Examinations directorate, its board is driving three new major developments. Firstly, a new curriculum is being developed for approval by GMC in 2019. The main proposed change is a shift of approach from the curriculum being competency based to one based on learning outcomes. Secondly, a new education strategy proposed for the College will bring major changes in how we deliver. The current examinations needed to be. The Health Services Research Centre (HSRC) has started to deliver on its excellent Patient Quality Improvement Programme (PQIP). Most importantly, PQIP will highlight the outcomes that underpin standards of perioperative care, and highlight areas where improvements can be made. Two other projects managed by the HSRC include the preoperative Audit Projects and the National Emergency Laparotomy Audit (NELA). Proposals are being heard for the HSRC to host a number of similar programmes and registries, which will be pivotal in delivering translational health services research, with the potential of rapidly making real difference to perioperative outcomes.

Clinical Quality and Research

The College’s Anaesthesia Clinical Services Accreditation (ACSA) is now a well-recognised and firmly established quality improvement programme, which helps hospital anaesthetic departments achieve, maintain and be recognised for the highest standards of anaesthetic service. The College’s Clinical Quality team should be congratulated for the fact that more than 50 per cent of the NHS anaesthetic departments are now engaged with the ACSA process. In the years to come, I look forward to more anaesthetic departments engaging with the process so that, as specialty, we can be in a situation where 100 per cent of departments are achieving the required high standards. The NHS is internationally renowned as the health care system that delivers the very best care process. However, there is much more to be done to bring our patient outcomes to where they need to be. The Health Services Research Centre (HSRC) has started to deliver on its excellent Patient Quality Improvement Programme (PQIP). Most importantly, PQIP will highlight the outcomes that underpin standards of perioperative care, and highlight areas where improvements can be made. Two other projects managed by the HSRC include the preoperative Audit Projects and the National Emergency Laparotomy Audit (NELA). Proposals are being heard for the HSRC to host a number of similar programmes and registries, which will be pivotal in delivering translational health services research, with the potential of rapidly making real difference to perioperative outcomes.

Healthcare Policy

Developing policy and engagement with NHS leaders and political decision-makers is an area where the College is becoming increasingly influential through the work of its Communications and External Affairs directorate. The NHS operates in a challenging climate of significant demographic shifts. People are enjoying longer lives, but with that comes a growing number of older patients with multi-morbidities. We need to make sure that those extra years are healthy and enjoyable ones. In the face of the ongoing financial pressure, concerns about recruitment, retention and wellbeing of NHS staff, and fragmentation of community, hospital and social services, it is vital that reform designed at the top delivers real change on the ground. I want to make sure that the College’s expertise helps shape and define reform that improves patient outcomes and the wellbeing and satisfaction of staff delivering patient care.

If we are going to narrow the margins of health-related inequalities across the UK we need to be bolder in our approach to perennial public health issues such as smoking and harmful levels of alcohol consumption. We also need to better address the growing problems of frailty, obesity and diabetes.

Realising parity of esteem between mental and physical health also needs to move faster from our rhetorical commitment to one backed with funding and resources. These issues, though not exhaustive, address areas I am not only personally interested in, but where I know our membership can help engineer solutions. As anaesthetists our position is unique as we engage in the care of two-in-three hospital patients, and as we look ahead to the anaesthetist as the ‘perioperative physician’, our role can grow further.

Perioperative Medicine (POM) therefore provides us with a platform to influence healthcare policy, and it is one of my aims to re-invigorate the POM agenda to improve healthcare delivery and patient outcomes. There is growing evidence that risk assessment, prehabilitation, shared decision-making, optimisation, enhanced recovery programme, and preoperative care in the appropriate environment can make significant improvements in patient outcomes and, at the same time, realise significant financial savings; for the NHS. My vision is for the College to work collaboratively with surgeons and other key partners to lead and drive the development and promotion of POM.

In conclusion, the future holds major challenges for us but also many opportunities. By working closely with you and our specialty partners, and by playing to our strengths, the College will remain well positioned to provide leadership, to continue to enhance the profile and impact of our specialty, and to help improve patient outcomes.

If you have any comments or questions about any of the issues discussed in this President’s View, or would like to express your views on any other subject, I would like to hear from you. Please contact me via presidentnews@rcoa.ac.uk.

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ISSN (print): 2040-8846 ISSN (online): 2040-8854
Outstanding departments awarded ACSA

Anaesthetists at the Lancashire Teaching Hospitals NHS Foundation Trust and Alder Hey Children’s Hospital have been recognised for providing the highest quality care to patients through the College’s Anaesthesia Clinical Services Accreditation (ACSA) scheme.

RCoA Council member Dr Russell Perkins presented the Lancashire Teaching Hospitals NHS Foundation Trust team (pictured) with their ACSA award at a ceremony at the Royal Preston Hospital on Friday 22 June. The trust’s anaesthetic department was described as cohesive and well-run, demonstrating a commitment to high standards in patient care and satisfaction.

In July, Alder Hey Children’s Hospital in Liverpool became the 22nd in the UK – and the first children’s hospital – to receive ACSA.

Why attend?

The group offers a structured yet open space to share your views and concerns, as well as to let us know what you value and would like to see more of.

Information and insight obtained from past focus groups has been invaluable, and we welcome your contribution.

The Best Western Invercarse Hotel is a five minute walk from Dundee airport and a short drive from Dundee train station. The event is free and lunch will be provided.

A limited number of places are available – book your space by emailing: engage@rcoa.ac.uk

Unable to attend?

Then why not join our Membership Engagement Panel? The Membership Engagement Panel includes fellows and members of all career stages, who help to shape the College’s work and strategy by sharing their thoughts, ideas and experiences via regular online surveys and occasional face-to-face focus groups.

For more information, please visit: www.rcoa.ac.uk/engagement

Have your say: a chance to shape the College’s priorities

The College is committed to improving the way we engage with our fellows and members. The membership engagement team has been running a series of focus groups, where we can hear your news and concerns. The next focus group will be held at the Best Western Invercarse Hotel, Dundee, on 7 November 2018, 12-3pm.

Our next Updates in Anaesthesia, Critical Care and Pain Management event takes place at the College on 25-27 September 2018.

The three-day programme gives you the opportunity to learn about new developments in the specialty and explore current topics affecting anaesthetic practice. Speakers will cover subjects ranging from state of the art day surgery and trends in opioid use to the National Emergency Laparotomy Audit.

View the full programme and book your place at: www.rcoa.ac.uk/education-and-events/events.

Can’t attend in September? We are holding another Updates in Anaesthesia event in London on 25-27 February 2019. Contact events@rcoa.ac.uk to be notified when booking opens.

Find out more and book your place at: www.rcoa.ac.uk/events

Leadership and Management workshops

The College’s Leadership and Management workshops are designed to help you develop the skills needed to be an effective leader in today’s NHS.

Aimed at senior trainees and consultants, each workshop includes a balance of plenary sessions, exercises with an emphasis on real-life issues, open discussions, group work and one-to-one conversations.

- Personal Effectiveness – 21 September 2018
  Learn how to recognise your strengths, weaknesses and preferences, and how you can increase your impact and effectiveness within your teams.

  Discover your behavioural preferences and how these impact on your working relationships. Increase your understanding of how to influence your trust and team to develop their service.

- Working Well in Teams – 14 November 2018
  Enhance your understanding of how teams work, as well as the challenges and benefits of working in a multidisciplinary setting. Learn how to apply key tools and frameworks learnt with your own teams.

- Leading and Managing Change – 5 February 2019
  Explore the tools and techniques needed for planning and managing change projects, and develop a personal plan for bringing about change in your workplace.

Patient Safety Conference

The annual Safe Anaesthesia Liaison Group (SALG) conference takes place in Newcastle on 22 November 2018.

Topics include anaphylaxis and the de-labelling challenge; evidence for and against checklists; forcing error and driving innovation; and updates on important safety projects and DPSIMS – the new national reporting system for critical incidents. The keynote speaker will be Dr Aiden Fowler, NHS National Director for Patient Safety.

To book your place, please visit the AAGBI website at: www.aagbi.org/education/event/3751

Updates in Anaesthesia, Critical Care and Pain Management, 25-27 September 2018

For more information, please visit www.rcoa.ac.uk/acsa

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Patient Safety Awards on 9 July.

Local NELA team wins at HSJ Patient Safety Awards

The Perioperative Quality Improvement Programme (PQIP) app launched

The team received the award for their innovative appointment of a nurse specialist, Kate Varley, to enhance outcomes for patients undergoing emergency laparotomy surgery, improving elderly medicine specialist input and reducing length of stay.

POMCTN holding two-day Autumn Meeting

Consultant members of Council are elected for a maximum of two terms and an aggregate of 10 years. The first term of office is six years and subject to re-election. The second term is up to four years. Terms of office can be extended if a Council member becomes a president or vice-president, subject to the maximum terms of those offices.

Trainee members of Council are elected for one four-year term.

The Duties and Responsibilities of Members of Council can be found here. All those wishing to be elected to Council are asked to read this document prior to seeking nomination.

Nominations for election to RCoA Council are now open.

Council comprises 24 seats, made up of:
- 20 consultant seats
- 2 SAS doctor seats
- 2 trainee seats.

The vacancies and timetable for 2019 are as follows:

■ 2 consultant vacancies: those eligible for nomination are those who are on the specialist register and are Fellows by Examination of the College of four or more years standing or Fellows ad eundem.
■ 1 trainee vacancy: those eligible for nomination are Fellows who will be in training when they take up their post on Council on 13 March 2019.
■ 0 SAS vacancies: there are no SAS vacancies this year.

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The Duties and Responsibilities of Members of Council can be found here. All those wishing to be elected to Council are asked to read this document prior to seeking nomination.
You may not want to hear about my first day in anaesthesia, but I will tell you anyway. The year was 1982, the venue St Thomas’ Hospital and my consultant was Harry Churchill-Davidson, then at the very peak of his clinical, academic and political powers (internet search his name if you have never heard of him). He shook my hand firmly and then held on to it a little longer than seemed necessary. He examined it closely and pronounced: ‘Feeble, boy. Feeble. We must make you strong’.

My first list comprised three total hip replacements. I held a mask to the face of each patient for a total of seven and a half hours. I had to use a straw to drink my beer that evening as my hand did not have the strength left in it to hold the glass. Six months later, I could crack walnuts with my first dorsal interosseous muscles and had the forearms of a navvy. I could also maintain a clear airway for pretty much any patient for as long as was necessary. I was not anything out of the ordinary in this: I was the normal product of an extraordinary apprenticeship. Much has changed since then and almost all of it has been for the better, – but not absolutely all of it. We are not the masters of the airway that we once were. Watch some younger anaesthetists manage an airway and you will quickly be convinced: the almost immediate insertion of the unnecessary Guedel, the use of the ‘three-handed airway’, the palpable anxiety if the laryngeal mask airway or tracheal tube does not find its target at the first attempt. This is not their fault, they are brighter, more committed, more thorough and working in a way more complex environment than we ever were or did. It is my generation’s fault. We have not given to them that which was given to us: the skill and confidence in the maintenance of an airway that only comes through experience. Algorithms are no substitute for this experience, nor is complex airway equipment with video screens, nor practice on a manikin, nor trips to meetings to be addressed by the glitterati of the ‘difficult airway’ community. While I am dishing out blame, I am afraid that some also has to be directed towards the laryngeal mask airway. I know that it is heresy even to consider criticising this most magnificent of British inventions, but its use has coincided with the degradation of our most basic airway skills. By replacing the formerly near ubiquitous ‘mask ’n’ airway’ technique, it has deprived us of the clinical skill that once set us aside from all other specialties. It is not of course the fault of the laryngeal mask airway: it is my generation’s fault, and I apologise on our behalf to the anaesthetists trained after Archie Brain’s invention was introduced in the later 1980s.

I have set out the problem; what then is the solution? First, we must decide whether we wish to have people regain these precious skills; I think we should. Secondly, we have to decide whether we wish to allow other professional groups to acquire these skills to allow us more time to focus on more cerebral activities such as perioperative medicine and manual skills. Not for us the raw physicality light on wider clinical knowledge that characterises the surgeon, not for us the chin-stroking contemplation and minimal direct patient contact that characterises the physician. Like our brothers and sisters in radiology and emergency medicine, we know stuff and do stuff, and are rightly proud of our capacity for both. We need to reclaim the fundamental skills that defined us; define us and will continue to define us, but how do we do this in the era of second-generation laryngeal mask airways, video laryngoscopes and difficult airway trolleys?

It’s a no-brainer – quite literally. For those patients whose safety would not be compromised by doing so, I think that we should use a ‘mask and airway’ rather than a laryngeal mask airway, and not just for the first three or six months of training, but for all anaesthetists in training and for as long as it takes for them to acquire the basic airway skills that we all once had. This will not only give us back our mastery of the airway, but I rather suspect that it will also drive down the incidence of ‘difficult airways’ and the need for ‘FONA’.

Competence is not simply the sum of competencies. It takes training; it takes practice; it takes experience. If our specialty is to retain manual skills at its heart, there has to be an apprenticeship element to our training. I know that this has been a dirty word of late, but we have to accept that you cannot master advanced manual skills simply by being signed off online for having done something well once or twice. It takes time and it takes repetition.

Let us go back to basics – for the sake of our patients. Let’s make anaesthesia great again.

Let’s all crack walnuts with our first dorsal interosseous muscles once more.
Anaesthesia Clinical Services Accreditation (ACSA)

The profession assessing the profession against professional standards for quality improvement

If not why not?

ACSA celebrates its fifth birthday with more than 50 per cent (96) of UK anaesthetic departments registered, 53 fully subscribed, and 21 accredited. As can be seen from Figure 1, there is broad geographical take-up across the UK.

If not why not?

Despite the many good professional and quality-of-care reasons to engage with ACSA, hospital management needs to be persuaded to pay the subscription! Perhaps the most compelling argument for a chief executive relates to the regulators’ recognition of ACSA.

The CQC have recognised the process from the start deeming ACSA accredited sites as low risk. A CQC inspector recently joined a review team as an observer and was unreservedly impressed with the quality and value of our process. The CQC regards ACSA engagement as an indicator of engagement with quality improvement by a trust and if not engaged, the CQC’s question will be ‘Why not?’

Other national regulators such as Healthcare Inspectorate Wales (HIW) and Healthcare Improvement Scotland (HIS) have begun to recognise the benefits of ACSA. ‘HIW recognises ACSA and takes account of the accreditation status of services as part of its surgical inspection methodology in 2017. ‘HIS recognises the value of professional accreditation. Our quality of care approach recognises ACSA standards and will take accreditation into consideration as part of the package of information about an organisation that informs review and inspection activity’. All standards have been mapped to HIW, HIS and CQC in the hope of reducing duplication.

Barriers to engagement?

There are many potential barriers to ACSA engagement in the highly pressured and resource-poor environment in which we all function – financial pressures, lack of time, conflicted workload, staff shortages, and the general low morale that goes along with all of these. However, the most important barrier is lack of engagement of the whole department. Once a department has this engagement they will make ACSA happen despite all the barriers noted above. The whole department must buy into the process if it is to be worthwhile, leading to quality improvement and accreditation, rather than being a tick-box exercise.

What’s gained through working towards accreditation?

Feedback is provided to departments following accreditation, and the full statements can be found on the website (www.rcoa.ac.uk/acsa/case-studies). There are clear themes emerging in terms of the benefits gained through ACSA engagement.

- Improvements in governance and the service.
- As the process requires an ongoing, systematic review of all areas of governance, it shows what policies you have already, brings existing policies together into one place, and highlights what policies you don’t have, enabling you to develop or update policies where there were gaps.
- ACSA drives a department to develop evidence of the quality of the service, and provides a clear framework for audit and quality improvement.
- The peer review process was an important step which unearthed issues that we couldn’t detect and guided us on how to make the changes which have had a positive impact on patient safety. ‘It has made us scrutinise our processes and policies over the entire patient journey to ensure we deliver only high-quality anaesthetic care.’ The improvements made have optimised our patients’ experience, such as safety initiatives, environmental and equipment enhancement, and staff education and training.

- Improved relationships with colleagues in a team effort with shared common goals. ACSA brings an increased respect for colleagues and mutual appreciation for the amount of hard work done by all, as well as motivating the department and bringing a great sense of pride ‘Working through the ACSA process has brought our whole department together as a team, working on a project which reflects the quality of care we strive to deliver daily’. ‘Working together for a common purpose has boosted department morale and team spirit.’

- Improved relationships beyond the department. ACSA provides an opportunity to listen to and collaborate with the broader theatre team and beyond, and to develop policies with impact beyond the department. ACSA gives the department an audience with the chief executive and medical director, and raises a department’s profile throughout the trust/board.

‘Like a domino effect, it also influenced our theatre staff and specialist nurses to evaluate their practice and ensure highest standards of care.’ The review provided a one-off opportunity to present all the excellent work we have going on in front of the chief executive and medical director.

- Accreditation provides a mark of quality that assures patients, as well as clinical staff, managers and regulators that the service is of the best standard. ‘Accreditation provides evidence that we are delivering high-quality care to our patients.’

- Leverage to defend the pursuit of quality in clinical practice in difficult times of austerity, when there is inevitably increasing pressure on quality. ‘ACSA gives greater authority and legitimacy to arguments for quality and a defence to professional standards. ‘During difficult times in the NHS it has been rewarding to participate in a project which has engaged the whole department in pursuit of quality.’

Use ACSA to celebrate what you do well – and to do better where you can.

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

The RCoA ACSA team can be contacted by telephone (020 7092 1697), or by email at: acsa@rcoa.ac.uk
ICM recruitment has been a yearly national process since the creation of the CCT programme in 2011, recruiting for the first time in April 2012.

Minor changes have been made each year (this year we used iPads for scoring) but a constant from interviewers has always been an appreciation that we’re fortunate to have high-quality applicants keen to join the specialty and a well-run system from Health Education England (HEE) West Midlands. Interviewers find interviewing a positive experience, and lay feedback has been excellent. A virtue of our smaller size is that we can run yearly face-to-face training for new interviewers and have Quality Assurance assessors present for the interviews, so that candidates can be reassured that the process is fair.

When applicants are coming from core and specialty training programmes and with trainees having different training backgrounds all in the same year, it’s important to be mindful that bias could creep into a recruitment process in many ways. It explains in part why we have more stations and independent scoring; and why trainees wishing to dual in ICM as well as anaesthesia must be interviewed and ranked against their peer applicants.

In 2018, 230 candidates were interviewed, and 143 accepted one of the 163 places on offer – an 88% recruitment rate. Yet again, we had more appointable candidates than posts, but candidates applying for ICM in a dual programme and already in possession of a National Training Number (NTN) for their other specialty are only able to accept a training number in their current training region, which has an additional impact on recruitment figures. This is an HEE rule, and one which we are currently unable to amend.

The quality of ICM applicants is high, with around 60–65% of those training in ICM also training in anaesthesia. Although there is a minimum appointable score (as for all specialties), the common reason trainees lose out on an offer is because they’re tied to a single region by virtue of holding an NTN already and they haven’t ranked highly enough against other applicants in that region to be offered a place. Trainees wanting to dual in ICM and anaesthesia need advice from trainers in both specialties in order to understand their relative chances of securing a training place for each specialty.

The 2018 bombshell of issues with the Royal College of Physicians (RCP) recruitment and offers process was dropped on the Friday afternoon before the first May Bank Holiday weekend. By the time the senior Faculty secretariat were informed, HEE had already taken the decision to withdraw not only all medical specialty training offers but also all offers for ICM training due to the potential for overlap. There had been no issues with the ICM recruitment or offers process, but at 20% of our accepted offers involved trainees coming from a medical background, HEE decided that the RCP offers error may have had the potential to impact on decisions made by medical candidates who had applied to ICM. As a result all ICM offers were withdrawn, and the offers process for ICM was rerun after the RCP had clarified the medical offers errors.

In the interim, the focus from the Faculty secretariat and senior trainers was on supporting trainees and getting confirmation from HEE over that weekend that no trainee in ICM who had accepted an offer would lose out. HEE agreed to put extra posts into the process if required. I am thankful to all at the Faculty and all the heads of school, training programme directors and ICM/anaesthetic trainers nationally, who put in a huge effort to reassure and support applicants at a very stressful time, using social media, phone calls and email. When the offers process was run, no one was affected in a negative fashion, and all previously offered posts were once again accepted.

Trainees in ICM, whether dual or single CCT, should be reassured that the Faculty and its trainers are there for them at all stages of their training.

Candidates can be reassured that the process is fair

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We also recognise that there is a burden in a doing an extra CCT, even where many competences have been carefully mapped to overlap; changes to the ICM curriculum will be occurring. Despite the frustrations, the attrition rate from the ICM programme is low (<5%) in comparison to the few specialties which monitor and publish their attrition rate (eg, 30% in Obstetrics and Gynaecology).

Trainees in ICM, whether dual or single CCT, should be reassured that the Faculty and its trainers are there for them at all stages of their training.

Reference

Faculty of Pain Medicine (FPM)

Opium: at the beginning...

Dr Barry Miller
Dean, Faculty of Pain Medicine

This year we welcome three new board members: Dr Nick Plunkett, who also serves as Chair of the Court of Examiners; Dr Lorraine de Gray, who also takes up Chair of the Training and Assessment Committee; and Dr Helen Laycock, who is our new trainee representative.

At the outset of this piece it is important to emphasise that opioid medication is an essential aspect of good medical care, certainly in the acute and the cancer pain models, and that, although more limited, it can be useful in some persistent pain problems.

But …

Over the last few years, there has been increasing national and international attention given to the issue of opioid prescribing. Concern over their widespread and persistent use, in the absence of evidence of efficacy and about significant side effects, is leading to a sea change in approach.

The Faculty has been proactive in this area, working with Public Health England to create the ‘Opioids Aware’ resource in 2015 – which remains a major stream of work.

This focuses on the long-term issues, but every long-term prescription starts with a first script for a first pain problem.

Recently the focus has been on the issue of in-hospital and discharge prescribing – where there is evidence in the US that stronger or longer discharge prescriptions are associated with longer-term, problematic use.

The issue of pain in the short and medium term following surgery is often poorly understood, and discharge prescriptions, and advice to patients and GPs are often vague and unclear.

For the majority, the situation resolves quickly but, for a significant minority, the pain may remain, change or worsen, and mechanisms for assessment, advice and early management are limited.

It is clear that improved guidance is important in this area. Therefore the RCoA and the Faculty are convening a joint working group to work with other colleges with the aim to fill this gap in postoperative care.

Revalidation for anaesthetists

Updates to the CPD approval process

In common with a number of other medical Royal Colleges we welcome applications for CPD approval of courses and events. The approvals process is based on Standards and Criteria for CPD Activities: A Framework for Accreditation published by the Academy of Medical Royal Colleges (AoMRC).

Events are reviewed on the basis of one CPD credit per hour of contact/guided learning, up to a maximum of six CPD credits per day, and the benefits of the scheme include that approved events appear in the College CPD Online Diary and on our website. All applications undergo a two-stage accreditation process: an administrative check by the RCoA Revalidation & CPD Team and then a technical review by an independent, specialist CPD Assessor who will be a clinician experienced in the subject matter.

The process is overseen by the independent CPD Board, and event providers are advised of the following two policy changes which were made earlier this year:

■ Submission of events – applications for CPD approval should be submitted at least six weeks ahead of the event taking place. Consideration will not be given to applications received less than two weeks before the event date and for any applications for retrospective CPD approval.

■ Events organised outside of the UK – where events are being held outside of the UK, consideration will only be given if a UK-based organisation is hosting the event or has made a significant contribution to its development. In addition, consideration for such an event can only be given if it can be demonstrated that it will be catering for a specialist audience and has content of such a specialist nature that UK-based doctors would travel there specifically to attend.

For any further information about the above please contact Chris Kennedy, Revalidation and CPD Co-ordinator, at cskennedy@rcoa.ac.uk.

Reference

As the NHS turned 70 in July, it is perhaps appropriate to reflect on how times have changed. Most of us will not remember a time before the NHS, but the changes within our living memories are dramatic. I can remember that, as a child a trip to the GP meant queueing in a shed outside the GP’s home, where you moved up the row of chairs until you reached the front door. There was no appointment system in those days, just a patient (excuse the pun) queue.

My father was a pharmacist, and his first task was learning how to neatly parcel medicine bottles in white paper. As a result, he was excellent at wrapping birthday and Christmas presents too! People would often consult him for a cough medicine or embrocation, for which he had a comprehensive book of recipes. However, like the cobbler’s children, at home we had scant supplies. Aspirin and iodine seemed to cure most things. When helping Dad in the shop, I was often struck by how many people coming in with a prescription would ask which item was the most important, as they could not afford to pay for them all. I daresay that still happens today as the charge is currently £8.80 per item. As the shop was in the Peak District, Dad delivered medicines and oxygen to people living in remote areas on his way home, and considered it all part of the service.

A trip to the hospital involved a train journey, and visiting hours, even in the children’s ward, were restricted to a couple of hours per day – no siblings allowed, and all gifts had to be pooled for the benefit of all children. I can remember, aged 7, recovering from an emergency appendicectomy in an adult ward, presumably because of a lack of beds. I felt well cared for and was made a great fuss over. My only complaint was that, when told I was going to theatre, I thought I was going to see a show and was very disgruntled to have missed it!

Things are so much more sophisticated and streamlined these days. People are hospitalised for the minimum time possible, and supported during their stay by family and friends. Things have moved on and, if I think about it, without the NHS many of us, including myself, would not be here today. So, thank you NHS, I am truly grateful for a comprehensive, free-at-the-point-of-care delivery. Long may you remain.

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Patient Perspective

**70 YEARS OF THE NHS**

As the NHS turned 70 in July, it is perhaps appropriate to reflect on how times have changed. Most of us will not remember a time before the NHS, but the changes within our living memories are dramatic. I can remember that, as a child a trip to the GP meant queuing in a shed outside the GP’s home, where you moved up the row of chairs until you reached the front door. There was no appointment system in those days, just a patient (excuse the pun) queue.
In truth, I think every anaesthetist knows that visceral discomfort when we haven’t got control, and when clinical events start to go astray. As a more junior anaesthetist it was a familiar feeling, present during what I would now see as mundane clinical work. However, it still returns with a bang on occasion, and I am startled to find my heart racing or my sweaty hands trembling. We all have a handful of cases where inner tribulation is seared into our memories; what follows is just one such case... I knew things were bad because at team brief the very senior obstetrician had begun to invoke God. I was genuinely unsure whether this was in jest, entirely serious, or somewhere in between. Nevertheless, the established facts were not favourable – a DGH with no interventional radiology, a lengthy quiet weekend, and an antepartum haemorrhage with very abnormal placenta. My consultant anaesthetist colleague used the choicest of profanities to convey his personal reflections.

I remember the fearful eyes of the poor lady during our preoperative discussions. Her only option was an emergency caesarean section and we were now entering a chain of possible outcomes. At the end she meekly asked us to ‘save my life’.

So, we meticulously prepared for the worst, large-bore access, arterial lines, central lines, cell salvage and a level 1 transfuser with a fridge stocked full of blood products. We induced and intubated using ketamine and adrenaline boluses. But she got worse. We summoned every available staff member including obstetricians and the cardiac arrest team. But she got worse. We started vasopressors and intubated using adrenaline and dopamine boluses. But she got worse. Within a few minutes, that familiar phrase ‘start CPR’ was declared, and my amygdala decided to start a full conversation with the rest of my brain. I imagined the next issue of the glossy MBRRACE report with my name and mugshot featured prominently. I remember having to consciously disengage from such thoughts of regret, guilt and doubt, knowing I could ruminate on them later.

For the next eight hours, clocks accelerated between episodes of cardiac arrest in theatre, emergency hysterectomy, yet more blood product transfusions, instability on intensive care, and more cardiac arrests. Eventually I found myself back in theatre alone completing copious notes. I saw the patient several times during her long recovery. She shed tears at not witnessing the first week of her baby’s life while in intensive care. Churlishly, I wanted to remind her how close she came to missing a lot more but I restrained myself.

So, whenever I get commended for my composure, I will gladly take the plaudit. I am more than happy to promote the fallacy that anaesthetists are necessarily calm and collected. But whenever my ego swells, a frequent occurrence I must confess, I remind myself of this.

As an SAS (Specialty and Associate Specialist) anaesthetist, it often surprises me when people remark upon my ‘calm’ manner during difficult emergency situations. Such comments encourage visions of myself, untroubled at the head of the bed while ward staff fall over themselves stricken with panic. Calmly, I glide away at the end of the situation, my theatre gown billowing behind me. A trail of junior doctors and nurses watch me leave, many covertly wiping away tears of admiration and awe. These recollections could not be more fictitious than if I should return to theatres by taking a short cut through Narnia.
Launch of NAP6 and selection of the topic for NAP7 – perioperative cardiac arrest

Launch of NAP6

The 6th National Audit Project (NAP) report, ‘Anaesthesia, surgery and life-threatening allergic reactions’, was published and launched in May 2018. In the July edition of the British Journal of Anaesthesia there were five papers summarising project results and the same number of editorials. A final paper describing the investigation of NAP6 perioperative anaphylaxis cases was published in Clinical & Experimental Allergy. In one respect, with the release of these many publications the NAP6 project comes to an end. However, there is more to be done.

First, the results and implications of NAP6 need further dissemination, and recommendations need acting on. NAP6 was the first NAP to be launched with significant social media coverage, and was launched with an infographic (Figure 1). The project also featured in more conventional media, including BBC national television and radio, the BBC world service, and the front page of the BBC health website. While such media exposure is of value in itself, the most important requirement is that the messages from NAP6 reach individual anaesthetists, allergists and immunologists to drive change. I am delighted that there was a considerable call for resources to enable presentation to departments – the NAP6 website features many resources, including the report itself, presentations from the launch as slidesets and videos, a summary slideset and a podcast (www.nationalauditprojects.org.uk/NAP6home).

Second, several themes which emerged from NAP6 merit further exploration and action by the anaesthetic community and our colleagues. Matters arising include discussions around the extent, breadth and variation in antibiotic prophylaxis for surgery, working with the independent sector to improve engagement with national audit projects, and perhaps further discussion on the recommendation that CPR should start when the blood pressure in an anaesthetised patient is <50 mmHg. Discussions and actions will take a while, but watch this space.

Figure 1 NAP6 Infographic

NAP7

The NAP cycle lasts 3.5–4.5 years and it is important that the enthusiasm and energy seen in the anaesthetic community in support of NAP6 is also harnessed for NAP7. With that in mind, there was a call in late 2017 for topics for the 7th National Audit Project. A total of 64 formal applications (including two from Australia) were submitted covering more than 40 discrete topics.

As always, the main requirements for a successful NAP topic are that it is: (i) important to patients, (ii) important to anaesthetists, (iii) incompletely studied, and (iv) so rare that it is not suitable for study by better or simpler methodologies. With this in mind, not all proposals were suitable for a NAP. Those not considered suitable did include several that might be studied by different methodologies, including SNAPs, other observational cohort studies, and even RCTs. Amongst these were complications of patient transfer, practices in perioperative and discharge opioid prescription and use, anaesthetic drug errors, and postoperative delirium and cognitive dysfunction.

The selection process included a long-listing and short-listing processes were listed. This then fed into the potential useful and popular topics were presented to small groups, and annual meeting, in which the topics session during the QuARC network – were invited to present on 19 June to a selection panel of broadly similar make-up to the short-listing panel. After this, the panel selected Perioperative Cardiac Arrest as the topic to take forward for NAP7. This has been ratified by the Clinical Quality and Research Board and College Council and is now formally the topic for NAP7.

Clinical management of the National Audit Projects

The workload required to plan, perform, analyse, report and disseminate a NAP should not be underestimated. It requires a coordinated and sustained effort from the clinical lead, the planning and review panel, and the support team at the College over a period of at least three years. Challenges are regulatory, logistic and academic.

The College will soon be advertising for a clinical lead for NAP7 as do look out for adverts on the College website and in our journals and bulletins.

Finally, I will be stepping down as Director of the National Audit Projects in the autumn. I would like to thank all those at the College, all NAP3/4/5/6 panel members, and every single anaesthetist who has contributed to any part of the NAPs during my involvement. It has been a genuine honour to be involved, and I wish those taking over the best of luck and look forward to the new developments that will take place with NAP7 and beyond.

Professor Tim Cook
Director of National Audit Projects
In September 2016, the RCoA Bulletin carried an article proposing an anaesthetic ‘quality faculty’. Our next steps were to survey the membership for their views on the idea, then take that advice to shape our network.

The membership survey undertaken in August 2017 gave us some very helpful advice as to what our focus should be, and the confidence that the College membership agreed with our proposal:

■ between 80% and 90% of respondents indicated that they agreed with the description of roles proposed for the quality faculty
■ 90% supported a local co-ordinator role to reduce duplication, coordinate quality improvement (QI) endeavours, give anaesthetists in training an opportunity to learn, and help departments share best practice
■ 80% supported the regional co-ordinator role, to share learning between departments and help coordinate trainee involvement across the region.

Members felt that the four tiers in the original proposal might be too many. Although many members said they would be willing to take on these roles, the main barriers to active participation would be willing to take on these roles, and training needs.

We defined our vision as: ‘To inspire and drive a QI culture across the NHS’. Our plan is to develop a network that is able to share best practice, enable collaboration, and help inform the RCoA agenda on quality improvement. This will be enabled by working both within a virtual space online and in face-to-face sessions, as well as developing connections within our own regions.

Sixteen regional leads were recruited in February, and convened in April to learn about network leadership principles and plan our next steps.

We looked at a number of network models, including the Health Foundation’s ‘5Cs’ wheel for effective networks which emphasises that networks function best when they are based around a common purpose.

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The role of Quality Network regional leads will be to communicate information and raise awareness of local and national projects, to connect with their local QI community, to provide a focal point for two-way linking between local trusts and the College, and to share resources.

There are a range of opportunities in anaesthesia, intensive care, and perioperative medicine to improve quality of care while providing efficient care that is value for money. Examples can be found across the NHS, where teams and organisations are already acting on these opportunities and demonstrating positive results. However, significant barriers remain, and the use of QI methodology is still patchy. Many improvement efforts fail to deliver the results expected, and we don’t have effective ways to share our learning – both the successes and the failures.

The RCoA Quality Network provides the opportunity to develop a consistent and coherent approach to quality improvement that will enable and support all anaesthetists to develop QI skills, engage in quality improvement, and share learning across different healthcare settings. The network will help in understanding the barriers that can impede frontline staff in contributing to and leading improvement work, and will serve as a support system to help anaesthetists develop the skills needed to make improvements while involving patients and working with our colleagues.

The network will be able to promote the role of quality improvement as part of everyday practice across specialties. This may include a range of approaches, including:

■ longitudinal QI projects coordinated by the network
■ development of more accessible QI training opportunities
■ development of ways to share best practice and improvement more effectively, both within our specialty and working with others.

Future development and next steps

In the coming months we will refine and share our ideas and look to recruit local leads in each department. As always, we are keen to hear your views. And look out for the Quality Network coming to your department soon.

Table 1 Quality Network regional leads

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Don’t see your region? Then no one applied to be the regional quality network lead. If you are interested in the role or know someone who might be, then email carolyn.johnston@nhs.net
Like most contemporary organisations, the College seeks to stay in touch with the needs and aspirations of its members. Our membership survey, conducted on an occasional basis, provides a channel for such communication. Importantly, the dialogue goes beyond passive information sharing and allows the College to try out ideas whilst they are at the concept stage. In the opposite direction our members offer free-ranging commentary and comments.

Humans are creatures of habit and this certainly applies to their interactions with medical journals. Over the years, many journals have experimented with format and delivery methodology often precipitating robust responses from their readers and in some cases backtracking. In 1981, the British Medical Journal introduced a mini-print format with a subset of its content presented in full but in a reduced (some thought barely readable) font size. Readers were assigned to a (changeable) category of General Practice or Hospital editions and received what was presumed to be their favourite content at full size plus a shrunken representation of the pages in which it was assumed they would be less interested. Despite ‘overwhelming endorsement’ from the Annual Meeting, mini-print didn’t find favour and was in due course abandoned. Given this history we should therefore tread judiciously before we fiddle around with our current offer.

Nevertheless times are changing. Anaesthetists are environmentally sensitive and many have expressed a desire to decrease their environmental impact by receiving journals electronically thereby saving the paper, plastic wrappings and haulage needed to deposit a paper journal on their doormat.

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The British Journal of Anaesthesia (BJA) has run its own experiments along the way. A reduced content edition of the journal branded ‘BJA Concise’ was planned, implemented, criticised and finally abandoned. Given this history we should therefore tread judiciously before we fiddle around with our current offer.

Nevertheless times are changing. Anaesthetists are environmentally sensitive and many have expressed a desire to decrease their environmental impact by receiving journals electronically thereby saving the paper, plastic wrappings and haulage needed to deposit a paper journal on their doormat. In this regard the July 2018 edition of BJA breaks a few records – weighing in at a monstrous 860 grams before adding BJA Education, the College Bulletin and some advertisements. Finally, internet usage is now ubiquitous. College members vote electronically and use web resources in every aspect of their lives. Why not dump paper and move to electronic only? Well, not all of us are ready... What about the train, the coffee room and (I dare I mention it...) the theatre? What indeed. The truth is that we’re not sure. The membership survey included some questions about how you prefer to receive your journals and we’re considering an (optional) hybrid containing elements of BJA and BJA Education. A project group is working on it so watch out for developments, keep telling us what you think and be open-minded if we experiment with journal formats and electronic alternatives.

If you have views about paper versus online-only or prefer both or if you yearn for or are appalled by the thought of a hybrid, please let me know (bulletin@rcoa.ac.uk).

Rob Sneyd is a former RCoA Council member and BJA board member now neither but working with colleagues to make sense of the options, respond to your views and offer you something approaching what you want.

References

BJA and BJA Education: time for a (paperless?) merger or leave well alone?

Would a shortened BJA/BJA Education hybrid delivered on paper and backed up by online full text of both suit our readers?
An interview with Norman Davies, Head of NHS SMART

Roland Esquire – The man with his finger on the pulse

It seems that every year we see the creation of a new NHS department charged with leading a major change to the way that the NHS works. Last year, we saw the birth of the Health Safety Investigation Branch (HSIB), currently called the Health Services Safety Investigation Branch (HSSIB) and shortly to be rebranded the Health and Social Services Safety Investigation Branch (HSSSIB). This year’s big healthcare launch is that of NHS SMART, which is an amalgamation of NHS Improvement and NHS Better, two organisations that will no longer exist after 31 July.

We interviewed Norman Davies, the head of the new organisation, in his office in Whitehall. Norman trained as a Communication Facilitator at the Middlesex Hospital in the late 1980s before entering hospital management and rising to become Chief Patient Advocate of the North West Derbyshire University Hospitals, Mental Health and Ambulance Service NHS Foundation Trust. He then joined NHS England’s head office function in 2008 as Deputy Assistant Head of Responsiveness, then Deputy Lead for Equality, Diversity and Growth, and more recently Senior Clinical Lead of the Forward Vision Group of NHS Better. We asked him why NHS SMART has been created and what he sees as its major strategic direction in the medium to long term.

‘Quality Improvement has been the biggest thing in the NHS since the last biggest thing before it,’ says Norman, ‘although I think that most of us would agree that it has proved to be even bigger than that, which is pretty impressive. The good news is that it has done exactly what it says on the tin; quality improvement has quite literally improved quality. This is a really good thing, and everyone at NHS Improvement and NHS Better deserves praise for having both improved things and made them at the same time a lot better – and when I say ‘better’, I mean better for everyone: better for our patients, their carers, their loved ones and their loved ones’ carers.

‘The effort put in by those who have tirelessly brainstormed the PPSP cycles that underpin quality betterment has quite frankly been tireless. A PPSP (plan-do-study-act) cycle, as you probably already know, is the natural successor to the PDSA (plan-do-study-act) cycle in that it cuts out the time-consuming and disruptive changes involved in actually doing and acting, allowing those who drive the betterment programme to focus solely on strategic oversight, and leaving the simpler, operational aspects to those asked to translate the PPSP cycles into what we call a ‘betterment escalator’ at a trust level.

‘However, all this success comes with problems. As the quality improvement programme has increased so dramatically in size in the last five years, it has become evident that more than 60 per cent of all NHS employees are now committed on a full-time basis either to clinical betterment or to quality improvement – or both, leaving only 40 per cent of NHS employees participating in some form of direct patient and carer care. Although this means that NHS clinical care is now better than it has ever been, we have to acknowledge that there is now quite a lot less of it than there used to be.

‘As the quality improvement agenda finds it harder and harder to find care that it can improve in quality – not only because the care is of such high quality but also because there is much less of it happening – it must appreciate that its resources have to be committed to an agenda that goes beyond quality improvement and towards the actual delivery of clinical care. This is where NHS SMART comes in. We are introducing a new programme in which we look beyond improvement and even beyond better towards what we call ‘best’, while increasing the amount of clinical work that we do – we call this ‘more’. This explains why the NHS SMART logo has the words ‘best’ and ‘more’ as pillars that support the word ‘smart’.

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‘We are going to hit the ground running on 1 August 2018. I have appointed Clinical Leads for More, Best, Safer, Responsive, More Efficient, Comprehensive, and Increasingly Diverse, and these seven clinical leads have already scheduled a series of face-to-face and virtual meetings that will run well into the New Year. This will allow NHS SMART to set out a detailed road map of how we get from where we are today to where we need to be tomorrow over the next few years. NHS SMART really does aim to be smart, and its goals will be Specific, Measurable, Achievable, Realistic and Timely, while also being Sustainable, Multidisciplinary, Academic, Repeatable and Terrific – SMART in every way!’
THE SCIENCE OF SELF-IMPROVEMENT

Dr George Madden
Consultant Anaesthetist
University Hospitals Coventry and Warwickshire

The concept of improvement science has existed in industry for decades. Reassuringly for the sceptic who might think this is managerial pseudoscience, it was developed by engineers and physicists in the early 20th century.

They had been tasked with working out why the technology they had been developing wasn’t translating into production, and they found that the production methods were so imprecise and disordered that any form of precision engineering was impossible.

They had no idea how to run a factory, so, as good scientists, they fell back on the scientific method. Unfortunately, most of the factory workers had no idea what this meant, so they developed a simplified cycle of scientific experimentation that we now call ‘Plan-Do-Study-Act’. Thus the concept of improvement science is that it empowers the people who are doing the work to change it.

Many will have heard this all before. There have been many attempts to bring this concept into healthcare using a variety of slogans – ‘Lean’ and ‘Sigma 6’ are just a couple of them. None have really taken hold. So, as a new consultant, I was invited to participate in a new iteration of this. I wondered, cynically, whether the rest of the department had already refused this poisoned chalice, or whether it was the fresh outlook of a new consultant that was needed. I came to realise it was somewhere in between.

The difficulty with bringing improvement science is that it requires systemic change. We must take, but then we must step outside them to see what direction we need to move in.

So that is what I did. I was asked to help with the flow of our orthopaedic patients through recovery. I sat down with recovery nurses, ward nurses, ODPs and managers. I saw how my daily annoyances were more to do with others trying to make their lives easier, not realising the effects they were having. The ward nurses, for example, were oblivious to how patients stacked up in recovery awaiting a ward bed, and how the theatres not infrequently ground to a halt as a result. I was oblivious to how the patient whose blood pressure was a bit saggy, or whose oxygen saturations were a bit borderline (although to my mind perfectly acceptable), became a huge problem on the ward, where medical support is less available.

We realised that the solution was obvious: we should all communicate better. Essentially, we needed to act as one team and not from multiple ‘silos’.

But if it was that easy it would never have become a problem. The attitude of ‘them vs us’ had become so engrained, and the reason was simple. When we are overworked and under pressure, we try to ease our workload at the expense of others. It’s such a normal part of our lives that it barely registers. But together we realised how it becomes like a tug-of-war, each of us making the other’s task more difficult – with the poor patient sitting in the middle.

As I tried to spread this revelation with new ways of working, I unsurprisingly hit resistance. But the most resistant of my colleagues weren’t those who instinctively disliked change. In fact, it was the opposite. Those were the grey-haired veterans who had once been at the vanguard of change, they had tried what I was trying, and finally, exhausted and despondent, given up.

So the real lesson I’ve learned is this: we need to stop blaming the system and to start blaming ourselves for being the system. Then we need to forgive ourselves – we’re only human. We’re not going to change overnight, but we can change, bit by bit over time. If we have the right tools to steer us in the right direction. And those tools, when we choose to use them, will work.
Asking an autistic trainee to learn normal social skills is like shouting into a deaf person’s ear and demanding that they hear.

- **Social skills** – Often there seems to be no logical process underpinning ‘small talk’, so attempts by an autistic trainee may come across as inappropriate. Patients require eye contact to feel safe, but it may feel too personal or intense to maintain eye contact with colleagues. Attempts to decipher an autistic trainee’s non-verbal communication based on neuro-typical body language can lead to the wrong conclusions. Smiling without eye contact, for example, could be misinterpreted as smirking. Atypical tone of voice may be misinterpreted as aggression, and, when concentrating, autistic trainees may forget to say please or thank you. Autistic trainees may not be understood when they fail to augment plain English with non-verbal communication, and may simply progressively raise their voice. An overloaded autistic trainee may require a stimulus-free period to be able to continue working.

- **Social anxiety** – Autistic trainees may have been classically conditioned to believe they will fail at social interaction. Avoidance of interaction may be misinterpreted as aloofness. Worry about upsetting colleagues is a major cause of stress; this may be worst after changeover and gradually reduce as trainees become familiar with their teams.

- **Attention** – Autistic trainees may forget to socially interact with staff while focused on patient care, especially when treating awake patients. Attempted social interaction during times of concentration (for example, when drawing up drugs) may cause irritation. Similarly, at critical times, they may not appreciate attempts at unrelated education from colleagues. This may come across as aloofness or rudeness, but it is just focused attention on perceived duty. It does not reflect lack of care for one’s colleagues. During conflict, an autistic trainee’s attention may be too focused for him or her to be aware that walking away is an option. Unrelenting pursuit of special interests can produce a boring colleague, but is useful for passing anaesthetics exams.

- **Intolerance of change** – Requirement for change should be explicitly stated with a logical reason. Another person interfering with drugs, anaesthetic-machine settings, or documentation may increase cognitive load on autistic trainees. Moving office and changing hospitals are particularly stressful, and are likely to cause dips in performance.

- **Sensory issues** – The sensation of uniform on skin, colour of theatre lighting, or grating of a singing operating-room practitioner are just some examples of things that can increase cognitive load on an autistic trainee. Conversely some tones of voice may be imperceptible unless deliberately being listened to.

- **Memory** – Some autistic trainees may need to write things down to compensate for limited working memory, yet have exceptional long-term memory. In the case of negative events the latter may be seen as grudge-bearing, but it also applies to ones own mistakes and self-loathing.

- **OSCE/Viva Exams** – Autistic trainees may not identify ‘the game’. If you tell them what you want, they will show you they can do it.

After reading this, one might think autistic people should not work in healthcare. Autistic people’s abilities vary just as the general population do. Patient care will always be the most important thing. Autistic team members can increase patient safety by challenging group-think. As long as my work is beneficial to patients and helpful to society, I will keep doing it. When there is somebody better to replace me I will stand aside. In the meantime, one fewer anaesthetist would not make the world a better place.

**References**


**Conflict of interest**

Venthan Mailoo was diagnosed with Asperger’s Syndrome during his 5th year of medical school.

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The autistic anaesthetic trainee: a personal perspective

Autism is defined by persistent impairment of social interaction and restricted interests, with repetitive patterns of behaviour. Texts on autism written by non-autistic individuals describe egocentricity; aloofness; lack of awareness of social rules; monologue talking; inappropriate use of voice, body language and expression; intolerance of change, and inability to sustain relationships.1,2

It might not be sensible for people to reveal unseen disabilities. Indirect discrimination is unavoidable, but I have experienced direct discrimination from medical students, a core trainee and a consultant. Asking an autistic trainee to learn normal social skills is like shouting into a deaf person’s ear and demanding that they hear. This personal opinion piece has been written to highlight issues for the one per cent of the population that are autistic, some of whom work with us and may not even know themselves that they are autistic.

- **Social cognition** – Autistic trainees are likely to take things at face value, and are less likely to follow group-think. Non-verbal cues and subtle communication may not be perceived. This can be mistaken for lack of empathy. Conflicting rules can cause excessive stress. Working with teams that unanimously disregard rules, such as taking shortcuts in the WHO checklist, can also be stressful. Expectations between doctor and patient tend to be explicit, and so are easier to manage. Similarly, strict adherence to perceived truth can create problems with colleagues, but can rapidly build patients’ trust. Perhaps truth and rule adherence are factors of reliability.

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When we initially arrived in the United Arab Emirates (UAE), I worked in Abu Dhabi for King’s College Hospital London, while my husband started at Mediclinic City Hospital in Dubai. Looking at the map before emigrating, we thought we could live somewhere in the middle and commute in either direction. Once we got here however, we realised there was nothing in the middle, except for a few date palms and the occasional camel! So, for a year we saw each other only at weekends, living in our respective Emirates.

I loved Abu Dhabi. It’s a wonderful, safe city with friendly people, stunning beaches, incredible sports facilities, world-class restaurants, and green open parks. There is a great sense of optimism for the future in the capital of the Emirates, and many projects are underway to increase its global profile – such as the recent opening of the exquisite Louvre museum.

Work at King’s was very simple day case anaesthesia and my year here was almost like a career break, providing me a very soft landing into a new country and culture. After a year however, I was offered a job at Mediclinic Dubai and, although I was sad to leave Abu Dhabi, I was delighted to be reunited with Andrew. My arrival evoked mixed emotions in him as apparently all my ‘stuff’ ruined the hitherto undisturbed feng shui of his man-cave (read: bikes, and bits of bike, scattered all over the place).

Dubai is a very different animal to Abu Dhabi. It’s an assault on the senses: a busy, frenetic, vibrant, mushrooming city. The United Arab Emirates didn’t exist 46 years ago, and yet now Dubai boasts the world’s busiest international airport, its tallest building, its only 7-star hotel, and a brand new Opera House. Like its neighbouring Emirate, Dubai’s global ambition and optimism is palpable.

The weather here is perfect between November and April, after which the temperature creeps up insidiously, exceeding 50 degrees by August, when stepping outside is an experience not dissimilar to inserting your head into a fan oven. Luckily, everywhere is air-conditioned and life continues more or less uninterrupted. Most activities are available, (even skiing!) and I spend my free time cycling, Cross-Fitting or going to yoga.

The majority of residents come from India and Pakistan (around 40%), and the rest from the four corners of the globe. This is a truly diverse place – in one pre-operative clinic, I counted 17 different nationalities on the list. Although English is the common language, I’ve been learning Arabic which seems to be a pleasant surprise to local patients. However, judging by their often bemused faces, I think my accent needs work! One cannot earn Emirati citizenship; instead, to be resident here, you must be working or sponsored by someone who is. This results in a generally healthy population although, as in the West, obesity and diabetes are increasingly problematic.

Mediclinic City Hospital is a busy, 240-bedded tertiary hospital (big for Dubai), offering everything except trauma which, by law, goes only to government-run hospitals. Government hospitals accept only Emirats and trauma victims; everyone else uses private facilities, and it is mandatory for employers to provide health insurance. At City, both the nationalities of the medical staff and the patient demographic reflect the local population.

The equipment we use is identical to that in the UK. Before my arrival, I heard rumours that opiates were illegal, but fortunately proved false and, apart from diamorphine, all of the usual drugs are available in theatre.

My contracted hours are 45 per week, but in reality we start at 7.30am and the day is dictated by the surgeons’ schedule, with no set finish time. All 45 hours are given to direct clinical care and, although we get seven days’ study leave and 30 days’ annual leave per year, there is no SPA time. We are allocated to one theatre each day, and any number of specialties might pass through. This means that I have anaesthetised over 1000 cases in the last 12 months, ranging from paediatric neurosurgery to day-case endoscopy, with most specialties and complexities in between.

On-calls are busy; the labour epidural rate is 95 per cent and around 40 per cent of women will have a caesarean delivery, although interestingly there are few emergency caesareans. I have anaesthetised for over 150 caesarean sections since arriving, and none has been a Category 1. I think this is because all care is consultant delivered, women are managed very actively, and decisions are made early. We have no anaesthetists in training, meaning that we are resident on-call approximately once a week, but because we are paid a bonus according to activity people are actually keen to be on-call and to work at the weekend. This scrambled my brain when I arrived – here, offering a weekend list to a colleague is seen as a favour! Most of the patients are ASA 1 or 2 and so anaesthesia is generally straightforward. All surgery is performed by a consultant, meaning it’s usually completed in a timely fashion, and in daylight hours. Although I work longer hours, the remuneration here is significantly higher; my monthly salary is around four to five times my previous net salary in the UK, and this income is tax free.

This is a truly diverse place – in one pre-operative clinic, I counted 17 different nationalities on the list.

Dr Kate McCombe
Consultant Anaesthetist
Mediclinic City Hospital Dubai

OUT OF THE FRYING PAN, INTO THE FIRE

(Part two)
Hosting a regional perioperative medicine meeting

On the 23 April, the West Suffolk Hospital (WSH) hosted the inaugural meeting of the East of England Perioperative Medicine Group.

This group was established with four primary goals:
- to promote perioperative medicine (POM) in the East of England
- to emphasise the importance of POM in improving the outcomes of surgical patients
- to facilitate implementation of the strands of POM by encouraging the sharing of ideas and pathways between healthcare providers in the East of England region
- to enthuse trainees and consultants to embrace the POM programme as part of their ‘lifelong learning’.

Bury St Edmunds was selected as it is geographically central in the region. The organising committee approached the College for support, and applied for an educational bursary which is awarded by the College to promote regional events (www.rcoa.ac.uk/premierebursary – the College has twice-yearly applications with closing dates of 31 May and 30 November). The meeting was successful in attracting five CPD points, and this contributed to the excellent attendance of delegates from throughout the region.

Dr Liam Brennan (President of the RCoA) opened the meeting by pointing out that the number of people living with multi-morbidity is increasing rapidly, and that £16 billion per year is currently spent on UK elective surgical care. He proceeded to demonstrate that reducing variability through effective patient pathways produced safer and more cost-effective care.

Dr Nigel Penfold (lead for the RCoA curriculum review) followed, with an outline of how POM forms an integral part of the GMC-approved CCT curriculum. He informed the meeting of the College’s recently published undergraduate training framework, which included the basic tenets of POM. He then highlighted the requirement and benefits of engaging in ‘lifelong learning’, emphasising that the College expects its fellows to be cognisant of developments in the field of perioperative medicine. A member of the WSH management team then spoke about the features that they would be looking for in a business case for a proposed project when asked for funding. This talk further highlighted the importance of Annex G (the curriculum section that covers quality improvement, and management), especially as anaesthetists are going to drive the agenda for quality improvement (QI).

Dr Fay Gilder then clearly demonstrated that frailty can be defined both physically and cognitively, and that there are now established strategies to minimise the perioperative harm arising from frailty.

Dr Andy Klein highlighted the fact that treatment of iron-deficiency anaemia is already a National Institute for Health and Care Excellence (NICE) standard, and pointed out that the CQC will shortly be assessing hospitals on their ability to achieve this target. Along with Dr Neely (Chief Registrar at Peterborough Hospital), he then discussed ways of managing iron-deficiency anaemia in the perioperative period.

Dr Patricia Mills spoke on the issues of prescribed opioid dependence. She highlighted the responsibility that anaesthetists have for prescriptions that they initiate, with particular emphasis on the information given to both patients and to primary care when a patient is prescribed medication with the potential for addiction. This included suggestions for both verbal and written ‘de-prescribing’ plans.

The afternoon featured talks on shared decision-making (SDM) and prehabilitation. Dr Jane Sturgess discussed the evolution from consent to SDM, and noted that sharing decisions about medical care is now fundamental to good medical practice (as defined by both the GMC and the NHS Constitution).

Mr James Hernon and Dr Mark Stoker introduced to patients.

The morning session was opened with closing dates of 31 May and 30 November. The meeting was successful in attracting five CPD points, and this contributed to the excellent attendance of delegates from throughout the region.

Finally, the Perioperative Quality Improvement Programme (PQIP) was introduced by Dr Jo Simpson. PQIP’s top five national quality improvement opportunities provided a unifying central theme for the day – recognition of and optimisation of treatment for anaemia and diabetes

1. recognition of and optimisation of treatment for anaemia and diabetes
2. promotion of individualised risk assessment
3. promotion of enhanced recovery pathways
4. promotion of individualised pain management
5. promotion of drinking, eating and mobilising (DiEaMing)

We believe that the programme was able to demonstrate that the RCoA’s perioperative medicine focus brings benefits for the patient, the community, the tax-payer and the profession.

This model of regional meetings has many advantages, and it can be easily replicated countrywide by local enthusiasts or schools of anaesthesia.

The PQIP run-charts to compare outcomes between hospitals within our network at the second meeting next year.
Although the Judgment was specific in regard to public duties, the group were united in concluding that the College should review all activities and practices in parallel with this.

CARRYING OUT AN EQUALITY ANALYSIS

Carrying out an equality analysis on all our policies and practices promotes equality, and is a way of considering the effect on different groups protected from discrimination under the Act. We feel strongly that, by embedding equality analysis across and within all College activities and by engaging all employees and representatives, the function of the organisation will be enhanced and we can best serve the needs of both the public and those who might suffer discrimination.

Differential attainment is a term used to describe the variations in levels of achievement that occur between different demographic groups undertaking the same assessment. This is a real issue and the data from this College are similar to all others, both in the UK and worldwide.

The examinations department collects and analyses a vast amount of relevant data, and has been open about disseminating its findings. Liam Brennan and Andy Lumb published an analysis of the state of play in the July 2015 Bulletin, Andy Lumb, Mark Blunt, Nikki Snook and Samara Branker updated this in the July 2018 Bulletin, which I would commend to you.

We would also like to acknowledge the immense contribution of Mr Graham Clissett, Head of Examinations, in supporting the College, its trustees, volunteers and staff in this area. Graham has overseen the overhaul of the examinations management of candidates with disability, ensuring a better understanding of this group, and a more sensitive, informed approach to dealing with them. All examiners receive exam-specific equality and diversity awareness training on a yearly basis, with resources, including three e-learning sessions, available on e-Learning Anaesthesia and through face-to-face coaching.

The group has also reviewed a considerable amount of material over the last few years, including the Fair Training Pathways reports prepared for the GMC by Professor Katherine Woolf and others at UCL.

This project explored reasons for poorer outcome in assessments and progression in BME and IMG doctors. Of the many potential issues, it seems likely that the instability produced by short clinical rotations (both within and between trusts) has a more significantly adverse effect on these groups. Conversely, a consistent and sympathetic mentor, College tutor or educational supervisor helps build confidence and integration, reducing the effects of physical and psychological disenagement. We must continue to resist the pressure to reduce trainee assessment to a paper exercise.

As a property owner, the College has always been mindful of the requirement to provide accessible buildings, ensure reasonable adjustments are made, and provides rooms for prayer and contemplation and breastfeeding facilities.

Internally, the College’s Head of Human Resources has been refreshing our policies to ensure compliance with the Act, incorporating due regard to PSEDS. In addition, to encourage staff to think about this issue, there is now mandatory e-learning in this area.

I have chaired the group for just shy of four years and have enjoyed this role. To keep it fresh, the baton is now passed onto Andy Lumb, who has chaired the group for just shy of four years and has enjoyed this role. To keep it fresh, the baton is now passed onto Professor Judith Hall, to whom I wish every success in ensuring College compliance is enhanced and strengthened.

PUBLIC SECTOR EQUALITY DUTY

The College is not a public body, but it does have significant public-facing functions. For this reason, it is subject in part to the general public equality duties set out in the Equality Act 2010 (the Act).

The Public Sector Equality Duty (PSED) stipulates that a public authority in the exercise of its functions must have due regard to:

- eliminate discrimination, harassment or victimisation and any other conduct that is prohibited by or under this Act
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not
- foster good relationships between different persons who share a relevant protected characteristic and persons who do not.

The duties outlined above were clarified in the High Court Judgment: BAPIO v RCGP and GMC [2014] EWHC 1416 (Admin), [the Judgment]. The British Association of Physicians of Indian Origin (BAPIO) contended that the RCGP Clinical Skills Assessment (CSA) directly and indirectly discriminates against International Medical Graduate (IMG) and BME candidates.

The Court found against these claims. However, the Judgment made it clear that the GMC is a public authority listed as such in the Act. The RCGP is not a public body, but does have a duty under the Act when exercising a public function such as the conducting of exams and award of certificates. Details of the RCGP charter were crucial in deciding whether they had responsibility for training.

These findings affect all medical royal colleges, and triggered action to acknowledge PSEDS and show due regard to these duties when exercising a public function.

A small College group was formed, meeting initially in November 2014, to oversee this issue – which is not one we are addressing in isolation. All the medical royal colleges, the AoMRC and the GMC have similar working groups, and there is sharing of best practice.

Dr Simon Fletcher
Chair, RCoA Public Sector Equality Duty Group and RCoA Vice President

Mark Blaney
RCoA Finance and Resources Director

Eliminate discrimination... advance equality of opportunity... foster good relationships
Promoting awake videolaryngoscopic intubation

Over 10 years ago, our department published in this Bulletin a simple ‘recipe’ for awake fibreoptic intubation. Much has changed in airway management since then – NAP4 has taken place, remifentanil is more widely used for sedation, and videolaryngoscopes are commonly used for tracheal intubation. The 2007 article argued that awake fibreoptic intubation should be within the capability of every anaesthetist, and offered a simple ‘recipe’ for the technique. Ten years on, we now aim to do the same for awake videolaryngoscopic intubation.

We think it is simple to learn and to perform, and that anaesthetists in training should use it as a first-choice technique when a patient’s airway is predicted as being difficult. We would like to think that, by creating a technique for awake videolaryngoscopic intubation that is as simple and foolproof as possible, we can create a ‘virtuous circle’ where increasing confidence leads to further and wider use, and so on.1

We wrote the guidelines below (see box on next page) to provide a technique template which was known to work and was easy to follow for those who did not use it frequently. We also aimed to provide a basic equipment list to ensure that everything required was readily available, and also reduce the time required to set up, as anaesthetic assistants would know what would be needed. We know many others have experience with this technique and would be pleased to receive practical suggestions from readers to create a compendium of tips and tricks for making the technique as simple, safe and pleasant for the patient as possible. We can be contacted at andrew.smith@mbht.nhs.uk.

References
3 Fitzgerald E, Holodniot, I, Smith AF. From darkness into light: time to make awake intubation with videolaryngoscopy the primary technique for an anticipated difficult airway? Anaesthesia 2015;70:387-392.
4 Dr Rendall et al. BTS guidelines for diagnostic flexible bronchoscopy in adults. Theses 2013:68:5-44.

Topical airway anaesthesia:
1 Lidocaine 10 mg per dose metered spray to tongue and oropharynx. 10-15 sprays initially. 4% lidocaine can be used if available. Ask patient to gargle with liquid, then spit out. Repeat.
2 Insert Guedel airway to test adequacy of anaesthesia. If not, repeat spray and gargle once more
3 Insert videolaryngoscope. If anaesthesia not adequate, repeat spray and gargle.
4 Spray vocal cords under vision from ‘scope. Inject 5 ml 2% lidocaine either:
a) through a 10 cm i.v. drip extension with mucosal atomisation device on end (MAD®; Medtrix, Telford, UK) [see image on page 42] directed near larynx OR, if MAD not available, b) tracheal tube placed in oropharynx until tip visible near vocal cords, then 18 Ch suction catheter with proximal end cut off, inserted to protrude through the end of tube near larynx. [Luer lock syringe fits this gauge of catheter]. If injections are timed to coincide with inspiration, lidocaine is drawn onto, and below, the cords.

Indications:
1 Known or anticipated difficult airway
2 Consider in obesity or obstructive sleep apnoea
3 Known/unsuspected cervical cord trauma or unstable neck (eg severe rheumatoid arthritis) and risk of aspiration

Contraindications:
1 Patient refusal/uncooperative patient
2 Care with periglottic masses: risk of developing complete airway obstruction or laryngospasm

Preparation:
Explanation of technique and consent
Drugs for inducing general anaesthesia when tracheal tube successfully in place.
Procedure:
Monitoring – Pulse oximetry/ECG/NIBP; capnography ready to attach
Oxygen eg. 4 L/min via nasal sponge/nasal ‘specs’
Sedation: remifentanil by target-controlled infusion; typically 0.1-0.15 mcg.kg/min initially, increased as needed, while working on topical airway anaesthesia, to achieve a Ramsay sedation score of 2/3. Midazolam 1 mg, or 20–30 mg of propofol, can also be given for anesmisa.

Notes:
• Maximum safe dose of lidocaine is taken to be about 8 mg.kg-1/4.
• Nebulisation of lidocaine prior to theatre is possible, but not thought to be effective and uses up some of the lidocaine allocation.
• Glycopyrrolate 3–4 mcg.kg-1 can be given i.v.; however, direct suction of secretions/excess local anaesthetic is easy with the videolaryngoscope.
• Ask patient to take deep breaths when tube approaching glottis to make passage easier.

Equipment checklist:
1 Remifentanil TCI pump
2 Midazolam/propofol
3 Videolaryngoscope
4 Guedel oropharyngeal airway
5 Tracheal tube, with stylet/bougie
6 Nasal oxygen sponge/ ‘specs’
7 Metered dose lidocaine spray 10 mg per spray dose
8 2% lidocaine
9 Lidocaine gel
10 10 cm i.v. extension with mucosal atomisation device (MAD®)
11 6 Ch suction catheter with proximal end cut off

University Hospitals of Morecambe Bay
Guidelines for Awake Videolaryngoscopic Intubation

These guidelines are to assist in the technique of awake videolaryngoscopic intubation. Consideration must be made in each case about anticipated difficulty of ventilation, intubation and patient cooperation. Consider merits of awake vs asleep technique or surgical technique.

Representative image of a mucosal atomisation device for topical anaesthesia of larynx.

Dr Billy Wilson
CT1 Anaesthesia, Royal Lancaster Infirmary

Dr Andrew Smith
Consultant Anaesthetist, Royal Lancaster Infirmary

Image: Mucosal atomisation device for topical anaesthesia of larynx.
It is a truth universally acknowledged, that a doctor in possession of outstanding study funds, must be in want of a course. And occasionally, one course stands head and shoulders above the rest. From flying an aircraft simulator and analysing non-technical skills with airline captains, to translating strategies for crisis management and error reduction from aviation to medicine – the British Airways (BA) Clinical Human Factors Course promises all this and more.

As Atul Gawande notes in The Checklist Manifesto: ‘[Pilots] learn that their memory and judgement are unreliable and that lives depend on their recognising that fact.’ Instead, they are drilled to take a deliberate, analytical approach to problem solving, akin to Daniel Kahneman’s ‘System 2’, of Thinking, Fast and Slow fame. Medicine, by contrast, has been slow to depart from its traditional emphasis on knowledge recall and pattern recognition, and still reverses clinical autonomy over procedural discipline.

Mindful of these concepts, we entered the flight simulators. Strapped into the cockpit of a £10 million Airbus A380 simulator, we navigated in pairs a simulation with a medical angle, requiring accurate communication, shared decision-making and console-based checklists. Dazzled by the array of controls covering every conceivable surface of the flight deck, my partner and I committed an early error due to ‘hearing without listening’ – a timely reminder of the dangers of distraction in an unfamiliar setting. With renewed caution, we proceeded and made the mission a success. After trying our hand at a manual landing, we proceeded to the cabin simulations. Cutaway aircraft cabins of all classes are sequestered within the academy, which, alongside real cabin crew, aircraft medical kit, manikins and sound effects, provided a refreshing perspective from the NHS to focus on non-technical skills.

After lunch, workshops addressed effective team briefing and challenging one’s colleagues. We also became acquainted with ‘the dirty dozen’ – a list of aviation accident risk factors concerned with human error, which includes such familiar stressors as distraction and fatigue, only one related to poor factual knowledge. The day finished with a lively discussion on ‘just culture’ open reporting, and its translation into medicine in light of the Bawa-Garba case.

The course was invigorating, and provided a refreshing perspective from outside the NHS. It reminded us that non-technical skills are not solely the preserve of the critical incident scenario, but are key to everyday success and securing the best outcomes for our patients.

Course details can be found at: www.britishairways.com/en-gb/hasb/ClinicalHumanFactors

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1 Tin R et al. Safety at the sharp end: a guide to non-technical skills. Ashgate Publishing Company, Aldershot 2006
5 Gawande A. The checklist manifesto: how to get things right. Metropolitan Books, New York 2010
6 Haynes AB et al. A Surgical safety checklist to reduce morbidity and mortality in a global population. NEJM 2009;360:491–499
Mike was an extrovert man of mercurial enthusiasms...

Michael Rosen, former President of both the College (before its ‘Royal’ elevation) and AAGBI, passed away in early May after a long illness. His death has been marked with the formal tributes that one would expect for such a figurehead of the profession but, as one of his research fellows and later as a friend, I wanted to offer a more personal portrait of a man who was truly a larger-than-life character.

Mike was an extrovert man of mercurial enthusiasms, and life around him was never dull. In what might have been one of the earliest examples of simulation training, I once saw him fall to the floor in the anaesthetic room, clutching his chest in front of a SHO, who reacted like a rabbit in the headlights. There was a moment’s dreadful silence, then he opened one eye and exasperatedly declared: ‘For goodness sake, I’ve had a cardiac arrest – how quickly can you get the defibrillator?’ On another occasion, he told me to invite Archie Brain up to Cardiff to demonstrate his new-fangled laryngeal mask airway (LMA). After a good lunch, we all gathered in theatre awaiting the first urology patient. Despite me signalling frantically behind Mike’s back, Archie insisted on telling him how this device was so non-stimulating that he could insert it into his own airway without gagging. I knew where this was headed and sure enough, Mike grabbed one of the only viable samples of the LMA in existence and shoved it into his own mouth, promptly vomiting up the chicken and diced carrots. The floor was cleaned, the LMA rinsed off under the tap, and we proceeded…

Mike’s lasting legacy comes not so much from his extensive research and publications, impressive though these were, but from his far-sighted ambitions for the specialty. Without Mike, you might not be reading the Bulletin of the Royal College of Anaesthetists today, as there may have been no Royal College. He tirelessly and unapologetically pushed anaesthesia to the top of the medico-political agenda, tackling politicians, civil servants, and entrenched interests with dogged determination, and shamelessly wooing entrepreneurs who might be persuaded to fund long-term projects. At one point, a chance encounter with Richard Branson even led to the disturbing prospect of the first Virgin Fellow in anaesthesia.

Mike would often arrange to bring young anaesthetists from overseas to Cardiff, at a time when this was a less common practice than it is now. Many stayed and some had stellar careers, although I still recall a poor chap from Japan with nearly no English trying to persuade elderly Welsh miners to have a capnograph tube taped to their buttocks to detect carbon dioxide as a marker of passing wind after cystoscopy.

In the final reckoning, and eccentricity and political nous notwithstanding, it is Mike’s charm, sense of humour, passion for great medical care and generosity of spirit that those of us who were lucky enough to work with him will remember. The world of anaesthesia is a quieter, but better world without him.

Reference
The issue of PA(A)s has anaesthetists divided along a fault line of strident rival opinions

Raison d’être
The NHS is experiencing an unprecedented increase in clinical workload. Despite an overall increase in personnel, workforce expansion has lagged behind the work intensity. Additionally, with an exponential rise in ASA 3–4 patients presenting for complex surgery, it makes intuitive sense for experienced clinicians to manage sicker patients, while less experienced anaesthetists or PA(A)s anaesthetise ASA 1–2 patients under supervision. With good planning, PA(A)s can assist in enhancing the efficiency of operating lists. A major advantage of PA(A)s is that they are ‘permanent occupants’ of the lower rungs of the service tier, and can help plug some of the gaps in the day roster.

Par contre...
At the time of writing, the Department of Health and Social Care (DHSC) has just concluded a consultation on statutory regulation for Medical Associate Professions (MAPs),1 which includes PA(A)s. The outcome of the current consultation is almost fait accompli, but until then there will be an understandable reluctance to train and/or recruit PA(A)s.

PA(A)s cannot practise with carte blanche. In the absence of full statutory regulation, PA(A)s are employed variably in ways that are often dictated by prevailing local circumstances. Extending the role beyond the defined limits set by the RCoA/AAGBI is controversial, and may convey the wrong message. Competition for practical procedures and ‘overcrowding’ in theatres are pointed out as additional concerns, but ménages à trois can be minimised by advanced planning of the theatre roster.

The strongest argument against expanding the PA(A) workforce is a financial one. They may be cheaper to train, and one cannot dismiss the value of PA(A)s’ daytime-only contribution comes at a price, and it is quite cheap. So, the assertion that recruiting PA(A)s is financially prudent is, at best, specious. There is resentment amongst many anaesthetists, who argue that they should significant responsibilities for not a lot more in remuneration, and in some instances substantially less. It may look moral currency, but the issue has the potential to strain working relationships within any department.

The experience with three PA(A) colleagues at Coventry bears out many of the points raised on both sides of the debate. Our PA(A)s work predominantly in trauma and orthopaedics, day surgery and colorectal theatres, supervised by consultants in a 1 to 1 or 2 to 1 ratio. They do not work weekends or nights, and presently do not have prescribing privileges. The PA(A)s appear to have settled down well since their appointment more than a year ago. Reassuringly, there have been no patient safety issues, nor have their individual competencies been the subject of particular concern. But, beneath that veneer of acceptance, many anaesthetists are still reluctant to supervise PA(A)s, and a few question the concept.

This debate is still delicately balanced. Of greater concern is the predicted significant shortfall in anaesthetists. There are worrying signs already, as anaesthesia is being squeezed to favour other secondary care specialties and primary care in the current DHSC policy. This cannot have a positive impact on recruitment into anaesthesia. As custodians of the specialty, we would be unwise to ignore the views of a substantial section of our community, many of whom are prepared to vote with their feet. In that context, an uncontrolled expansion of PA(A)s could prove to be a major faux pas. There are examples elsewhere, like nursing, where the numbers of healthcare assistants has grown rapidly, often at the expense of nurse numbers, with its attendant consequences. It is unthinkable that such a fate should await anaesthesia. But, skills shortages are often the instigators of change, and that may be reason enough to trigger an expansion in the PA(A) workforce. ’C’est la vie!" The views expressed in this article are solely those of the author and does not in any way represent or reflect the views of the RCoA.

Reference
1 Consultation into regulation of MAPs – RCoA response (bit.ly/2AHxNrD).

PA(A)s de problème?
Musings of a jobbing anaesthetist on the RCoA Council

Oui, I am learning French! It is part of a larger plan to prepare for a major change in my longstanding daytime routine. That shift is due when I supernannuate from the ‘gas bubble’ that has been my savoir-faire for a few decades. It is slow going, as with age memory plays little tricks. ‘Pas de problème’ I say, as I am not alone in facing up to inevitabilities in life.

In some respects this anecdote is a microcosm of modern anaesthesia. The specialty has also been shaped by embracing and adapting to many a change en route. A tour de force for patient safety, anaesthesia is confronted by the latest ‘winds of change’, urging the specialty to adopt a new course. But, one ‘thorny’ issue has unsettled anaesthetists, dividing them along a fault line of strident rival opinions. You know what I am getting at — Physicians’ Assistants, (Anaesthesia) PA(A)s, la bête noire to some.

A 2017 GAT survey about the role of PA(A)s betrayed the anxieties of our junior colleagues. Given the controversial nature of the subject, it is worth taking a critical look at arguments for and against PA(A)s. I must declare a conflict of interest as I work alongside a few at Coventry.
Two branches of the Marston family have had involvement in the field of anaesthesia. One branch has been forgotten; the other is well known, having driven significant developments within the specialty.

Robert Marston (Figure 1) (1853–1925), son of a Leicester pharmacist, was in dental practice in the city. As part of this he had a dental anaesthetic practice and developed an apparatus – ‘Marston’s Stationary Anaesthetiser’.1

![Figure 1 Robert Marston](image)

which produced known concentrations of chloroform using a variable-orifice air-entrainment system. He also named it the ‘Patent Life Preserver’ (Figure 2) due to his belief that accurate knowledge of the concentration of chloroform was vital in ensuring safe anaesthesia, and that death under anaesthesia was due to uncontrolled concentrations rather than to the concept of ‘status lymphaticus’. This opposed the views of the anaesthetic establishment of the time.

In Marston’s apparatus, a known volume of chloroform was vapourised in a large iron tank, which was then pressurised with a hand pump. The outlet contained an injector with a variable-orifice air-entrainment system; the concentration of chloroform delivered to the patient could be calculated from a table, and depended on the pressure and the orifice size. This was the first anaesthetic use of the venturi effect.2 His apparatus and concentration tables were described in his book, The Anaesthetist’s Pocket Companion.

He also invented cheek-piece pairs which allowed delivery of the vapour to the mouth. This combination of the pressurised tank and the cheek pieces allowed anaesthesia for longer procedures than normal in the dental surgery at that time. He also developed a lightweight portable apparatus. Later, he used the tank with nitrous oxide as the gas in which the chloroform was vapourised. Robert Marston was not only an inventor, but also a businessman, having a small factory producing dental apparatus and nitrous oxide.

In the early 1900s he was a vociferous campaigner for the rights of dentists to be allowed to practise anaesthesia, and fought against three potential parliamentary papers restricting anaesthesia to medical practitioners.

He based his arguments on the belief that dentists gave many more anaesthetics than doctors and were more experienced. He sent letters and papers arguing the case for the dentists to MPs, ministers, and the prime minister. He also arranged meetings, published pamphlets, and gave lectures to support his views. These campaigns were successful.

In 1911–1912 he was involved in a medico-legal dispute concerning a patient who inhaled debris during an extraction. He won on appeal, but at a high financial cost, and he seems to have then become much less vociferous. He believed in principles we would agree with today – that the anaesthetist should not be the operator, and that the concentration of anaesthetic agent being delivered to the patient should be known and monitored.

At least two of his four sons, who were all dentists, continued to use apparatus with nitrous oxide. One son devised an aluminium tank as a step-down to the pressure from a cylinder, and this was in use in the late 1930s. He also invented a chloroform vapouriser to go with this tank.3 Another son used the Marston Stationary Anaesthetiser with nitrous oxide in his dental practice, possibly until the 1950s. Robert Marston’s apparatus seems to have been ignored in writings by contemporary anaesthetists,4 and later by his nephew (the other branch of the family), perhaps because of his defence of dental practitioners providing anaesthetic services.

There is little need to describe his nephew’s well known achievements. He qualified as a dentist, then as a doctor, training in gynaecology before becoming an anaesthetist. This was Dr AD Marston (1891–1962), based at Guy’s Hospital. His influence is well known as a prime mover in qualification and training for anaesthetists leading to the Diploma in Anaesthetics (DA) Examination in the 1930s. He was president of the Association of Anaesthetists of Great Britain and Ireland and the Section of Anaesthetics of the Royal Society of Medicine. His most significant achievement was, of course, being largely responsible for the development of the Faculty of Anaesthetists (of which he became the first dean) and the setting up of the FFARCS examination. This was probably through his useful interaction with the president of the Royal College of Surgeons in gaining support for the specialty’s academic recognition. Ultimately his achievements led to the establishment of the RCoA.

References
1 Marston R. The anaesthetist’s pocket companion. Marston and Par, Leicester 1899.
3 Marston RW. Personal communications 1982.
Dear Editor,

I was delighted to read the article by Dr Kish Ramachandran, the very slow march to a paperless NHS (Bulletin 2018;108:34-35), which highlighted the failure to adequately put in place a national electronic patient record system. It seems hard to believe that the NHS first announced it would go paperless in 2002, seven years before I attended Medical School. Whilst other sectors including banking and policing have moved forward with electronic systems, the NHS remains stuck with the pen and paper approach.

Over the past 9 months I have battled with focal hand dystonia (writers cramp). The condition results in involuntary cramping when attempting to write and may be caused by excessive writing with a poor pen-holding technique. It has made clear and legible note-taking a constant struggle. When day to day documenting becomes such a challenge, it emphasises the amount we rely on paper within the organisation and the disadvantages this has.

As my writing continues to deteriorate, I cannot help thinking that had the NHS suitably prepared and then implemented an electronic system within secondary care sixteen years ago, I would not now be facing the prospect of having to switch to a career where electronic record keeping is more commonplace.

Dr Richard Christie
CT1 Anesthetic Trainee, Swansea

Dear Editor,

Audit and quality improvement projects for trainees

Among the many excellent talks at Anaesthesia 2018, The International Meeting of the RCoA held in May at the British Museum was that given by Mary Dixon-Woods. Mary has been asking the question does quality improvement (QI) improve quality. QI is frequently advocated as a way of addressing problems with healthcare yet evidence of its effectiveness has remained very mixed.1 One review concluding QI can have a ‘negative association with financial costs, worker satisfaction and inconsistent effects on process outcomes.’1

Listening to this as a trainee, my ears prickled up because at annual ARCP meetings we are asked to submit evidence of our undertaking in either an audit or QI project. Indeed as a CT1 I had taken part in iHySe, NELA and SNAP 2 yet was told none of these projects were sufficient to ‘tick the box’ and in CT2 I would need to conduct a few small, self-designed audit or QI projects.

I do not dispute the value of postgraduate trainees being able to understand, design and implement QI projects (recently featured in Bulletin May 2018) as stated by the GMC3 and RCoA4 but feel that the expectation of needing to produce one annually ultimately leads to the wrong motivational drive to undertake the task.

In addition, participation in large scale, more long term national projects such as NELA should be greatly encouraged. Data compilation for NELA, for example, can often fall to a select few who are championing the project at the local level. If trainees could take greater leadership of such projects at a local level, maybe presenting updates at teaching or departmental meetings this could also help to maintain momentum among colleagues.

As many authors, QI needs to build an ‘infrastructure that enables learning about successful efforts and less successful efforts,’ unless data collected is shared, it becomes meaningless.

I wonder whether the college would consider allowing participation in nationally led projects as part of audit or QI when it comes to ARCP sign off? It seems unrealistic to assume every trainee will design and conduct a meaningful audit or QI, and even if this was the case they could lead to ‘reinvention of the wheel’ which may intensely problems not fix them.

Dr Grace Bickmore
CT2 Queen Elizabeth Hospital, London

References
2 K Fry, Quality Improvement (QI), An anaesthetist in training’s perspective in 2018, Bulletin, May 2018, No191, 18-9
3 GMC, Generic Professional Capabilities Framework, 2017 [link](https://www.gmc-uk.org/)
4 RCoA, CCT in Anaesthetics (Annex G), 2010, [link](https://www.rcoa.ac.uk/download/)

Dear Editor,

Thank you for offering me the opportunity to respond to Dr Bickmore’s letter regarding audit and quality improvement projects for trainees. I am delighted that she was inspired by Professor Dixon-Woods’ talk on this subject at the Anaesthesia 2018 meeting. The learning outcomes for Quality Improvement Science are set out in Annexe G of the core.1 In summary the requirements for Core, Intermediate and Higher training are to participate in and mentor others in local QI projects respectively. Trainees are only required to provide evidence from a single project for each stage of training and there is no curricular requirement for annual participation.

Gaining such experience is essential to ensure that all CCT holders are able to undertake quality improvement projects. This requirement is also explicitly set out in the GMC’s Generic professional capabilities framework2 which establishes standards of practice in Quality Improvement for CCT holders across all specialties. Schools of anaesthesia should be urged to follow the exact requirements of the CCT curriculum and local requirements that may encourage higher numbers of low value projects are discouraged.

Participation in national projects is also strongly encouraged for all trainees although such experience does not replace the skills developed in leading projects locally. Trainees should be provided with suitable time and support to participate in national projects, especially at the later stages of training. However, with nearly 5000 anaesthetic trainees currently registered in the UK4 it is probably unrealistic to make such participation mandatory. Work is in progress on a new curriculum for anaesthetic training which is expected to be introduced in 2020. This area will be thoroughly reviewed with widespread input sought to ensure that training in quality improvement meets the GMC standards and needs of services whilst also allowing trainees to develop additional expertise.

Dr Chris Carey
Chair, RCoA Training Committee and RCoA Council Member

1 G Bickmore, audit and quality Improvement Projects for trainees. RCoA Bulletin
2 CCT in Anaesthetics Annex G [2010], RCoA, [link](https://www.rcoa.ac.uk/download/)
3 Generic Professional Capability Framework. GMC, 2017 [link](https://www.gmc-uk.org/)
4 Workforce Data Pack 2018. RCoA, [link](https://www.rcoa.ac.uk/download/)
College Tutors Meeting 2018

Poster competition winners

At the recent College Tutors Meeting in Leeds, the submissions for the annual Poster Competition were judged. The three highest-scored abstracts were selected for oral presentation at the meeting. Dr Joseph Lipton was awarded first place, with Dr Amanda Zacharzewski in second place, and Dr Ian Densham in third.

An outcome-based curriculum for the novice period

Dr Joseph Lipton
Medical Education Fellow,
King’s College Hospital NHS Foundation Trust

Dr Asootsh Barry, Training Programme Director, South East School of Anaesthesia
Dr Helen Statham, RCoA College Tutor,
Princess Royal University Hospital
Dr Bernd Oliver Rose, Training Programme Director, South East School of Anaesthesia

Figure 1: EPAs for the novice period

Consultants will be familiar with the novice who completes the Initial Assessment of Competencies (IAC), but is not yet ready to work on call. This may be because assessing individual ‘competencies’ in isolation relates poorly to the expectations of the workplace.

Figure 2: A model for future implementation

We followed Ten Cate’s guide for EPA curriculum design to create an EPA-based curriculum for the novice period. We defined the novice period in terms of the clinical activities trainees must perform with indirect on call consultant supervision. Figure 1 shows the two EPAs and how they are related.

We provided a workbook for trainees containing a range of learning activities for each EPA, including formative and summative assessments. We also outlined the expected knowledge, skills, attitudes and behaviours.

Trainee’s progress was framed around ‘supervision levels’, level 1: permission to observe; level 2: permission to act with distant consultant supervision; level 3: achieving supervision level 4 earned a ‘Statement of Agreed Responsibility’ (STAR). The STAR represents formal recognition of the trainee’s progress and amounts to ‘entrustment’ of responsibility for an EPA. Trainees also completed the standard IAC.

Educational value

The EPA curriculum had clearer learning objectives than the IAC:
Trainee 6 – ‘I think the IAC as it stands is a piecemeal set of jumps that you have to clear…whereas this forces you to make an assessment of your overall ability to achieve the end goal which is going on the on call rota’.

Educational challenges

Not all trainees used their assessments to guide their learning:

Trainee 7 – ‘I was pretty sure I was going to be given a supervision level’.4

Logistical challenges

Consultant 8 – ‘you look at that list [of IAC competencies] and they have rapid sequence ticked off…you’re doing a rapid sequence that morning and they are absolutely hopeless at it. You think, “well do they have this signed off!” With the EPA system…you’re assessing the whole picture…to see whether they can achieve a certain supervision level’.

Managing the ‘critical progression point’

Consultants identified advantages of the EPA curriculum over the IAC:

Consultant 1 – ‘The EPA curriculum over the IAC was challenging and affected the trainees’ experience.

Ideas for the future

There are educational benefits of an outcome-based curriculum using EPAs and improved management of critical progression points may also have patient safety implications.

Overemphasis on ‘assessments’ was seen to perpetuate a box-ticking mentality. In Figure 2, multiple sources of information are used to make judgements about withdrawal of supervision. In particular we advocate regular ‘Supervised Learning Events’, framed around clear outcomes to capture the feedback and reflection that underpins learning. Inclusion of a transparent remedial process is designed to destigmatise the need for additional training and make the process more robust.

An updated version of the curriculum can be obtained from its authors via email: Lipton@knh.net / oliver.rose@knh.net

References


Acknowledgements

Thank you to Drs Emma Jackson and Iram Ahmed for help with curriculum development and to Drs Andrew McKechnie, Chirag Patel and Daniel Abel for supporting in their departments.
New online resource for anaesthetic trainees becoming parents

Dr Amanda Zacharzewski, Dr Bernadette Lomas and Dr Kirsty MacLennan, HEE, North West School of Anaesthesia

Early pregnancy is an exciting, worrying and confusing time. Combine that with a job in anaesthesia and there are even more questions to ask! Accessing information is a time-consuming challenge not only for the pregnant anaesthetist, but also for College tutors and educational supervisors who are often approached for professional advice and support. Many have questions regarding occupational risks, maternity leave and pay, keeping-in-touch days and return-to-work programmes. Wouldn’t it be ideal to have all that information in one place?

Our aim was to produce a resource that is easily accessible, up-to-date and has all the relevant information in one web location – a guide for the pregnant anaesthetist. We envisioned that our target audience would be pregnant anaesthetic trainees, college tutors and educational supervisors. We describe an evolving website that was developed with pregnant anaesthetists in mind; however, following the consultation process, we recognise that our stakeholders want the site to be more inclusive. Areas addressing paternity leave and shared parental leave are also to be included as the website evolves. We hope that this online, easily accessible resource will assist not only anaesthetists training within the North West region, but potentially trainees of all disciplines, nationally.

Key findings include:

- over 96 per cent of trainees and new consultants, and 82 per cent of College tutors and educational supervisors felt that an online resource relating to occupational hazards, maternity leave, etc, would be useful.

Initially the concept was developed with pregnant anaesthetists in mind; however, following the consultation process, we recognise that our stakeholders want the site to be more inclusive. Areas addressing maternity leave and shared parental leave are also to be included as the website evolves. We hope that this online, easily accessible resource will assist not only anaesthetists training within the North West region, but potentially trainees of all disciplines, nationally.

PEACHY: Peer-to-peer education in anaesthesia for children and young people

Dr Ian Densham, Dr Matthew Beardmore, Dr Rachael Garlick and Dr Danielle Franklin, Derriford Hospital, Plymouth

Senior paediatric trainees wishing to pursue RCPCH Specialty Interest (SPI) modules in Paediatric HDU currently face a paucity of time and resources to support them. Many existing resources are poorly adapted to their needs, and gaining leave to attend them is difficult. We set out to develop De novo a full peer-to-peer teaching programme in paediatric anaesthesia and critical care, mapped to the RCPCH curriculum, organised around local paediatric registrars’ availabilities.

Beginning with a review of the RCPCH HDU curriculum, we proceeded to canvass opinion of local paediatric anaesthetists and prospective attendees to produce a PEACHY curriculum. This covered the sciences underpinning anaesthesia and critical care, the basic provision of anaesthesia and advanced management of emergencies. Bespoke teaching materials were prepared for eight 3-hour sessions combining classroom, simulation and practical workshops. Content was cross-referenced to our curriculum document and covered in a cyclical fashion allowing candidates to consolidate their learning. This pilot project regularly taught two local senior paediatric registrars. Initial, midpoint and final competency questionnaires measured candidates’ progress. Detailed feedback was sought for every session and used in a continuous quality improvement process. All sessions were written and facilitated by two ST5 anaesthetic registrars, and the whole process was overseen by a local paediatric anaesthetic consultant.

Candidates’ self-rated confidence in core anaesthetic basic science topics increased markedly by an average of 50 per cent. The sessions’ overall and teaching quality rating were on average 93 per cent and 98 per cent respectively. Candidates universally felt their confidence on the topics had improved, confidence in certain scenarios scored lower after the course, suggesting newly discovered ‘unknown unknown’ knowledge areas.

The PEACHY course is, to the best of our knowledge, a novel attempt to specifically support paediatric registrars in gaining paediatric anaesthesia and critical-care competencies. This self-designed peer-to-peer inter-specialty teaching programme was well received and significantly increased candidates’ confidence across a wide curriculum. The enhanced understanding of each other’s specialties and the support of colleagues wishing to pursue H5U SPIN modules can only serve to improve care for critically unwell children. We plan to repeat this teaching locally, but feel that this programme may also be of particular interest to trainees in other hospitals and regions.

Reference
1 RCPCH: A Framework of Competences for the Level 3 Training Special Study Module in Paediatric High Dependency Care, April 2019.
The medical community was shocked by the conviction and erasure from the Medical Register of Dr Bawa-Garba, who many believe was simply in the wrong place at the wrong time. Kevin explained the background to the estimates of avoidable hospital deaths, which have varied from a quarter of a million annually in the US to Helen Hogan’s 2015 contention that avoidable deaths are rare, and not a good measure of quality of care. Kevin showed how poor data gathering had caused gross overestimation of the number of avoidable deaths, but the media, politicians, and others with vested interests have repeatedly used erroneous statistics, despite being corrected by experts in the field. He went on to dissect statistics, despite being corrected by media, politicians, and others with vested interests.

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NEW TO THE COLLEGE

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

Deputy Regional Advisors Anaesthesia

North Central London
Dr S Brocklesby, Barnet Hospital

College Tutors
(re-appointments marked with an asterisk)

Scotland
Dr K A Fraser (Glasgow Royal Infirmary) in succession to Dr G A Gallagher

England
East of England
Dr R Kere (Norfolk and Norwich University Hospital NHS Trust) in succession to Dr H Croddall

Dr G Kahl (Bedford Hospital) in succession to Dr A Rashid

East Midlands
*Dr A Gore [Glenfield Hospital]
Dr N Usman (St Bartholomew’s Hospital) in succession to Dr D M Dancey
Dr J Noble [Royal London Hospital] in succession to Dr C Dempsey
Dr G Kandosamy acting tutor for Dr F Murray [Whips Cross Hospital]

London
Imperial
Dr Katherine Homer

North Central London
Dr Nilar Myint
Dr Kenny Elliott

North West
Mersey
Dr Matthew Wood

North West
Severn
Dr J Loader [Weston General Hospital] in succession to Dr G B Hodscura

West Midlands
Birmingham
Dr A Daws [Russell Hall Hospital] in succession to Dr C E Brennan
*Dr T Day-Thompson [Hereford Hospitals NHS Trust]

Yorkshire & the Humber
West Yorkshire
Dr K Jepp [Harrogate District Hospital] in succession to Dr T Collyer

South West
Severn
Dr D Evans [Torbay Hospital]

Scottland
East of Scotland
Dr Fiona Bull
Dr Daniel Celnik

North of Scotland
Dr John Chalmers

West of Scotland
Dr Graeme Brown
Dr Kathryn Hill
Dr Sumit Gajree

Scotland

South West
Peninsula
Dr Mark Albu-Samra
Dr Thomas Teare

West

Dr Elizabeth Hood
Dr Matthew Bell

Wessex
Dr Daniel Growcott
Dr Jonathan Huber

Yorkshire & The Humber
East & North Yorkshire
Dr Rama Varadan
Dr John Titterington

West Yorkshire
Dr David Mor

Dr David Mor

Dr Rama Varadan
Dr John Titterington

APPOINTMENT OF\nFELLOWS TO CONSULTANT\nAND SIMILAR POSTS

The College congratulates the following fellows on their consultant appointments:

Dr Sanjeev Agrawal, Queen Elizabeth The Queen Mother Hospital
Dr Andrew Biffen, Derriford Hospital, Plymouth
Dr Abigail Clarke, Hull & East Yorkshire NHS Trust
Dr Daniel Celnik, Forth Valley Royal Hospital
Dr Neel Desai, Guy’s and St Thomas’ NHS Foundation Trust
Dr Sumit Gajree, Queen Elizabeth University Hospital Glasgow
Dr Andrew Hartopps, Darent Valley Hospital
Dr Theresa Hinde, Torbay Hospital, Devon
Dr Adam JT Slack, East Lancashire Hospitals NHS Trust
Dr Katherine Haynes, Royal Devon and Exeter Hospital
Dr Fiona Yau, Broomfield Hospital, Chelmsford

APPOINTMENT OF\NMEMBERS, ASSOCIATE\nmembers and associate fellows

Associate Fellows:
Dr Tomislav Ruzman
Dr Bernhard Freitag

Member:
Dr Neil B Roberts

Affiliate:
Dr Rayzen N Abdulrahman
Dr Konrad G R Wallesbocher
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-examiners

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 in 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**

- **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 gclissett@rcoa.ac.uk or 020 7092 1521 or Email:**

**THE CLOSING DATE FOR RECEIPT OF COMPLETED APPLICATION FORMS IS: MONDAY, 8 OCTOBER 2018.**

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**CONSULTATIONS**

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

**Originator**

1. **Joint Committee on the Draft Health Service Safety Investigations Bill**
2. **Association of Anaesthetists of Great Britain and Ireland**
3. **Royal College of Obstetricians and Gynaecologists**
4. **Association of Anaesthetists of Great Britain and Ireland**
5. **National Institute for Health and Care Excellence**
6. **Royal College of Paediatrics and Child Health**
7. **Association of Anaesthetists of Great Britain and Ireland**
8. **National Institute for Health and Care Excellence**
9. **General Medical Council**
10. **NHSEngland**
11. **Clare Marx Review**

**Consultation**

- **Call for evidence: Draft Health Service Safety Investigations Bill**
- **Guideline on safe transfer of the brain-injured patient: trauma and stroke**
- **Each Baby Counts Report - Anaesthetic Care**
- **Anæsthesia Team Guideline**
- **Draft guideline on Abdominal aortic aneurysm: diagnosis and management**
- **Safeguarding children and young people - roles and competencies for health care staff**
- **Safe provision of anaesthetic services in magnetic resonance units guidelines**
- **Chronic obstructive pulmonary disease in over 65s: diagnosis and management (update)**
- **Welcomed and valued' guidance for medical educators on how to support disabled students and doctors**
- **Evidence Based Interventions**
- **Review of gross negligence manslaughter and culpable homicide in medical practice**

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**DEATHS**

With regret, we record the death of those listed below.
- **Dr Thomas Young Anderson, Tasmania**
- **Dr Clement James Barraclough, North Yorkshire**
- **Dr Thomas Norman Calvey, Cheshire**
- **Dr Peter Julian Duff, Queensland, Australia**
- **Dr John Godfrey Farer, Newton Abbot, Devon**
- **Dr Shree Padmanabhan, Cheshire**
- **Dr Stephanie Saville, London**

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

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**ANNUAL CONGRESS DUBLIN, IRELAND**

**26-28 SEPT 2018**

**AAGBI’s flagship meeting for the international anaesthesia community comes to Ireland**

**BOOK NOW!**

[www.anualcongress.org]
The Perioperative Quality Improvement Programme (PQIP) is an exciting research study running in the NHS. The aim is to improve outcomes of major surgery, by using information provided by clinicians and patients to drive quality improvement.

Launched in December 2016, over 80 sites are now collecting data on patients undergoing complex surgical procedures. Data on processes, complications and patient-reported outcomes and are fed back to sites in near-real-time, through live online dashboards and quarterly reports. This rapid feedback is aimed at supporting and facilitating local Quality Improvement projects. Many local projects are already underway!

PQIP is adopted onto the National Institute for Health Research’s portfolio of studies, meaning hospitals can get help from their local clinical research network to recruit patients and collect data. New sites are still welcome to join the study, so if your hospital is not yet participating please get in touch!

www.pqip.org.uk | pqip@rcoa.ac.uk | @PQIPNews

‘PQIP is a unique multidisciplinary initiative’
Dr Liam Brennan, President of the Royal College of Anaesthetists

‘Data are essential to quality improvement’
The Health Foundation

‘The exam is over and no matter how it went I want to sincerely thank you all for all you efforts. I couldn’t have imagined taking this exam without Mersey and the Writers Club. You are such a wonderful team!’
— Final Written Candidate, March 2018

‘Thank you very much for all your efforts - I am relieved to say I passed both the OSCE and SOE. I doubt I would have without going to Mersey. This was my first go. I felt thoroughly unready having had to contend with building work at home for the past four months and the closer I got to the exam week the more unnerved I got. I went on another course about a week before going to Mersey and had a moment of “why am I even here?” after my first practice viva there. I felt like I might as well not bother going to the exam. I had little confidence as I headed to Mersey. Having said this by the end of the course I felt the whole enterprise was a success as I had reached a state of detachment and just wanted to get the exam over and done with!”
— Primary OSCE SOE Candidate, May 2018

‘I have passed the OSCE/SoE, in no small part thanks to the Mersey Course! The preparation for the OSCE was thorough and really helped me focus on the difficult areas. There were questions that were almost identical to the stations in the OSCE and Viva Practice Sessions and this really helped me relax and rest in between those that were more unexpected! Thank you again, I really enjoyed my time up at Mersey!’
— Primary OSCE SOE Candidate, May 2018
Innovation is the theme for this year’s Winter Symposium and the varied programme will feature a mix of lectures, short updates and debates with the addition of airway workshops to refresh your front of neck access (FONA) and fibreoptic techniques.

Experts will bring you up to speed with recent changes in practice and explore what the next five years may bring. Topics include:

- novel analgesics
- how NAP6 will change your practice
- recent curriculum and training advances and the impact to you
- obstetrics
- recent changes in paediatrics
- have your say: can technology improve your hospital communications?
- and many more...

This event sold out in 2016 and 2017 – book soon to avoid disappointment!

Registration now open!
CPD credits 10
#RCoAWinter

Gain a deeper insight into prehospital medicine, the increasing importance of anaesthetists performing echocardiography and the lessons learnt from dealing with the aftermath of a terrorist attack in the UK.

Discover data visualisation approaches to help you get the most out of your hospital’s NELA dataset.

UK leaders in perioperative medicine will be discussing the varied ways in which it is transforming care and improving outcomes for patients.

Other topics include:

- Opiate sparing anaesthesia  
  Dr Euan Shearer
- End of life care in ICU  
  Dr Lawrence McCrossan and Dr Joe Cosgrove
- Intravenous lidocaine  
  Dr Beth Perritt
- The high risk obstetric patient  
  Dr Chris Breaton
- Anaesthesia for the morbidly obese  
  Dr Euan Shearer
AIRWAY EVENTS

Obtain, maintain and enhance difficult airway management skills within a small group teaching environment at our airway events. Supportive and expert faculty provide a hands-on and interactive approach to learning, enabling you to practice and refine everyday, as well as specialised, airway techniques.

Airway Workshops

Appropriate for all grades of anaesthetic trainees, specialty doctors and consultants, these workshops enable you to learn care technical and non-technical skills including:
- flexible bronchoscopy
- supraglottic airway devices
- awake tracheal intubation
- videolaryngoscopy
- front-of-neck access
- airway guidelines.

“Excellent for all levels and a vital reminder of some potentially lifesaving airway techniques” June 2018

Advanced Airway Workshop
18 September 2018 | RCoA, London

Enhance and refine your existing specialised airway skills. Aimed at senior trainees, airway leads and anaesthetic consultants.

“Great equipment, very credible faculty” September 2017

Tracheostomy Masterclass

Combining small group discussions, skill stations and simulation scenarios, this masterclass brings together a multidisciplinary faculty to address the major issues from tracheostomy insertion to decannulation. The course will assist you in troubleshooting issues before a critical emergency develops.

“Excellent, lots of new learning and experiences to apply to day-to-day care” March 2018

ANAESTHETISTS AS EDUCATORS

“Truly practiced what it preached. Some great practical teaching advice, tips and thoughts to reflect on. Thank you!” June 2018

Simulation Unplugged
3 October 2018 | RCoA, London

Gain the necessary knowledge and skills to develop your simulation-based teaching. Take away practical tips and ideas that you can put into practice straight away.

Teaching and Training in the Workplace
8–9 October 2018 | RCoA, London

Take your knowledge of educational concepts, learning theories and styles to the next level. Leave equipped to set objectives, structure your lessons and deliver feedback effectively.

An Introduction
31 October 2018 | RCoA, London

Get to grips with the fundamentals of adult learning and small group teaching, understand how best to deliver effective feedback, and discover where you can create opportunities for teaching in theatre.

Accredited by the Academy of Medical Educators (AoME)

By attending An Introduction and Teaching and Training in the Workplace, and completing the associated homework, you will have a shorter application process for membership of the AoME.

UPDATEs in AnAesthesiA, critical care AND pAIN MAnAgEMENT


Final few places remaining

Join us for three days of forward-looking discussion on the latest ideas in anaesthesia. Discover new developments on the horizon from today’s thought leaders, learn how best to combat the growing issues you will face in your anaesthetic practice, and have your chance to question the experts.

• What impact will AI have in the surgical theatre?
• What the results of NAP6 will mean for your practice
• Improving anaesthesia on a global scale
• How can we improve efficiency in the operating theatre?

For more dates and locations, see www.rcoa.ac.uk/events

LEADERSHIP AND MANAGEMENT

Consisting of interactive group exercises, plenary sessions and discussions, these workshops will help you develop the necessary skills to be an impactful leader.

Personal Effectiveness
21 September 2018 | RCoA, London

Gain a deeper understanding of your strengths, weaknesses and preferences, and increase your impact and effectiveness within your team.

Introduction to Leadership and Management: The Essentials

Uncover your behavioural preferences and compare these to others, exploring how it impacts your working relationships. Learn how best to influence the Trust and your team to develop their service.

Working Well in Teams
14 November 2018 | RCoA, London

Discover what makes a team successful and discuss the challenges and benefits of working in a multi-disciplinary setting. Practice applying the tools and frameworks learnt in a group setting.

Leading and Managing Change
5 February 2019 | RCoA, London

Explore the tools and techniques needed for planning and managing change projects and develop your own personal plan for bringing about a desired change in your workplace.

Full programme available online...
Aisys CS²
LOW FLOW. HIGH IMPACT.

Designed to help you confidently perform low-flow anaesthesia and reduce anaesthetic agent waste, **End-tidal Control** provides **automated target control** for volatile anaesthetic agent and patient oxygen during general anaesthesia.

- Digitally enabled target control
- Decision support for non-automated low flow
- Advanced ventilation for neonates to adults
- Automated Vital Capacity and Cycling lung ventilation procedures
- Advanced Breathing System (ABS)

GE Cares is a collaborative learning platform where healthcare professionals can: **connect, share** experience, publish content and **learn** new techniques. Benefits include direct access to clinical webinars, protocols, clinical cases and scientific publications, helping improve skills.

www.gecares.com

For more information, please contact:
GEHealthcare.EducationLeader@ge.com
STATE OF THE ART 2018
QEII CENTRE – LONDON – 10-12 DECEMBER
WORLDWIDE VIEW BEDSIDE DELIVERY

CUTTING-EDGE TOPICS FROM ACUTE, CRITICAL AND PERIOPERATIVE CARE
- LEADING SPEAKERS AND NEW FACES - INNOVATIVE SESSION FORMATS: LEARN, THINK, DEBATE AND NETWORK - NEW GENERATION INTERACTIVE E-POSTERS
- ACCREDITED FOR 15 CPD FROM THE RCOA (PENDING)

4 TRACKS AND OVER 30 SESSIONS, INCLUDING:
TRAUMA: FROM ROAD TO RESUS • PERIOPERATIVE MEDICINE • MATERNITY CRITICAL CARE • DECISION-MAKING • PARAMEDIC2, INTEREST & INHALE TRIALS • RADIOLOGY MASTERCLASS • MEDICO LEGAL, NEGLIGENCE & MANSLAUGHTER • INNOVATION & NEW TECHNOLOGY • ECHO AND ULTRASOUND • SEPSIS: THE ASHES • NEURO & BURNS • FRAILTY & CRITICAL CARE • ADAPTIVE PHYSIOLOGY • THE ROAD TO RECOVERY • NEW PARADIGMS IN CRITICAL CARE BIOLOGY • QUICK-FIRE SPECIALIST UPDATES • AND OTHERS

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