Dr Cathy Stannard
NHS Gloucestershire CCG

The opioid epidemic:
A disaster in waiting?

Dr Aidan Fowler
National Director of Patient Safety

By bringing together speakers from across the intensive care family, we offer programmes packed with captivating topics and emerging research.

The Intensive Care Society also runs two renowned accreditation programmes, with training courses provided across the UK.

FICE (Focused Intensive Care Echo) is a practical solution to training in focused transthoracic echo for adult intensive care. This accreditation model brings together the best of current methods and insights from echo trainers across the UK.

A trainee will need to complete:
- A FICE basic echo course
- A log book of 50 studies
- A final triggered assessment

Once completed you can apply to be a FICE mentor and then supervisor status to help aid other trainees on their journey.

CUSIC (Core Ultrasound in Intensive Care) is a modular training pathway for achieving accreditation in focused ultrasound intensive care.

The concept of ‘core’ or ‘focused’ ultrasound is that patients are imaged at the bedside as an extension of the clinical examination to either rule critical pathology in or out (usually by asking specific dichotomous questions) or to guide invasive procedures.

A trainee will need to complete:
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- A log book of 50 studies
- A final triggered assessment

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**From the editor**

**Welcome to the May Bulletin.**

It gives me great pleasure to be able to introduce this trainee issue of the Bulletin, featuring a series of contributions by anaesthetists in training, and led by the redoubtable Katie Samuel from the College’s Anaesthetists in Training Committee. The chosen title for the front page, ‘Growing resilience and developing excellence’ elegantly captures in five words the competing challenges that face the modern doctor. Stressed by working hour demands, patient pressures and demands for increasing efficiency; while maintaining and improving quality of care would be a daunting task for anybody, but I am sure that readers of this issue will be left in no doubt of the commitment and drive of our future leaders. From perioperative medicine to research and national audit, anaesthetists in training are at the forefront, and it is comforting to know that, as I descend into old age and physical infirmity, my care will be delivered by such skilled, knowledgeable and committed professionals.

Stress, resilience and burnout feature elsewhere in the Bulletin as well, with thought-provoking articles from Lucy Williams and Carol Pellowe, Mental health and well-being of practitioners are, of course, very ‘trendy’ issues, and while some of us might be tempted to make light of them, I believe that their importance cannot be overstated. Not only do we owe it to ourselves and our loved ones to be as emotionally healthy as we can, but we owe it to our patients as well. A stressed, burnt-out doctor is unlikely to be giving of his or her best.

Anaesthetists in training feature elsewhere in the journal as well. I would highlight the article by Tom Munford, Seetal Aggarwal and Thomas Fletcher, where they describe how they became involved as key members of the ACSA preparation team when the College were invited to Nottingham to credential the quality of their anaesthetic care. As well as being able to represent the views of trainees to the assessors, they describe a valuable exposure to and insight into the issues that face clinical directors and training leads tasked with delivering high quality care. The lessons to trainees are clear: encourage your department to seek ACSA accreditation and get involved in the process.

Jaideep Pandit continues his series of stimulating articles, and here turns away from his recent focus on theatre efficiency to a topic that exercises many of us: workload versus income. From its name alone, the ‘Income Death Zone’ is not a place where any of us would want to be, and his careful financial analysis is recommended to anyone considering doing a few extra waiting list initiatives. Are you sure you want to work for no extra income? Or would you rather reduce your tax burden by gift-aiding to the World Federation of Societies of Anaesthesiologists, as suggested by David Wilkinson? Something of a no-brainer, I would suggest.

Finally, as befits a forward-thinking and eclectic journal like the Bulletin, we have published a poem! Reena Ellis’ contribution illustrates the tension between professional satisfaction and emotional and physical exhaustion that comes with an obstetric night on call, and in doing so reflects the reality of some of the more conventional articles in this issue. Any other poetical contributions will be gratefully received.
The President’s View

In conversation with Dr Sarah Muldoon, ST7 Registrar and new Council Member

In this month’s Bulletin we wanted to put the focus on anaesthetists in training. So I invited newly elected Council member and anaesthetist in training, Dr Sarah Muldoon, to provide the perspective of a current registrar. Originally from Kilmarnock, Sarah is an ST7 working in London who has been active in NHS affairs, including being an outspoken critic of government policy during the junior doctors’ contract dispute.

We were also joined by the College’s Head of Policy and Public Affairs, who acted as an ‘interviewer’ and is referred to in the piece.

The following article is a write-up of the conversation Sarah and I had in mid-February, just a few weeks before she took her seat on Council.

Sarah Muldoon (SM): I put myself forward for Council because I believe the College has been a strong advocate for its trainees and has stood up for us on issues such as wellbeing. But, there are a couple of areas where I feel our work/life balance could be improved and there could be a role for the College to do more.

One of the key issues is the design of rotas, since these can make it very difficult to sustain a satisfying social and family life or interests like a sporting activity or artistic hobby, as often we don’t have any control of our working patterns. We can’t easily personalise our shift patterns or explore approaches such as self-rostering. What are your thoughts on this?

Ravi Mahajan (RM): You raise quite a few issues. Firstly, I’d like to highlight the new curriculum that we are introducing from December 2020 onwards, which will be outcome-focused and not so fixated on how much time you’ve spent doing one thing.

We are mindful that rotas can be inflexible, so how can flexibility be introduced? Part of the problem is the rigidity of training structures. It’s like an elevator that you step into, press the button, and then are whisked to the top floor without much time to think. So where are the opportunities to step off at the sixth floor and consolidate your experience – in my view, that’s what we need more of.

SM: I think that anaesthetics is ahead of other specialties in this respect, but I wonder how possible it is to embed greater flexibility when service provision is so stretched?

RM: Local leadership from place to place demonstrates that this can be handled in different ways, and that some ways are better than others. Different deaneries take very different approaches, but I hope that the College’s new outcomes-based curriculum will provide some uniform improvement.

SM: There’s also the issue at the individual department level…

RM: Some training programme directors are very hands-on and will tailor as much as they can, while there are others that, every six months, introduce a ‘master rota’, and then you’re told you’ll have to postpone your wedding… I’m taking an extreme example…

SM: Hmm, well extreme, but not unheard of…

RM: Well in those situations, the College can definitely provide a greater steer on what good looks like – achieving the right balance between service provision and individual decision-making.

SM: How do you feel that, as anaesthetists in training, we might be better empowered to challenge institutions and the way of doing things in our own departments when the consultant says ‘…back in my day’? This may be in clinical scenarios where a suggestion of using newer equipment is disregarded, or it might be related to fatigue or wellbeing…

RM: If you are in a position where you are made to feel like a subordinate, you will find it very difficult to challenge orthodoxy. That is a very bad position to be in for your own professional development, but it’s also a danger to patient safety, and that makes it a bad position for the consultant to be in too.

I don’t think we have a strategy for cultural change, but things are changing where the patient-safetyagenda makes the case for change.

[The interviewer raised the issue of media depictions of a ‘snowflake’ generation, and asked how this impacted upon relationships between junior and senior staff]

SM: There’s a parallel between the media depictions of the ‘snowflake’ or the ‘millennial’ generation and the depiction of the current cohort of doctors in training, and that doesn’t help. But, more than just the attitudes and expectations, of anaesthetists in training has changed in the past 20 years: everything has transformed – the environment, the technology, the types of patients…

SM: I think anaesthetists in training are coming to realise that we are not automatons, and we shouldn’t be expected to be martyrs for patient care but, rather, we should have expectations of the system for the support of our health and wellbeing.

Related to what we’ve been talking about, I want to talk about resilience. Particularly, I wanted to hear your thoughts on the somewhat cynical suggestion that organisations may be training healthcare professionals to be more resilient as a solution to workforce pressures, rather than addressing the root causes of staff shortages and patient demand.

RM: I think that we need doctors who are able to adjust their performance, in realtime, when adversity presents itself. Having the confidence to change your approach and adjust your performance is what I would understand as being…

I think this generation acknowledges our individual and collective impact on the world around us, and this is in parallel to our increased awareness of our own wellbeing, and by extension that of our patients.

I want to safeguard my personal welfare, as ultimately I can’t deliver patient care effectively if I don’t have my basic needs met. I do think that staff wellbeing is being recognised as a patient-safety issue, so ‘pandering’ to what might be perceived as ‘snowflake’ issues, is actually going to improve the service for patients.

RM: When I was a registrar we were called something different: we were the ‘privileged generation’. The answer is not to look back, but to look at what we need now, regardless of what it used to be like.

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resilient in a clinical setting. What you are alluding to is an idea that trainees should learn to work when they are hungry, tired or dehydrated, and then calling that resilience. I cannot accept the idea that putting up with poor welfare standards can be synonymous with resilience.

I would like to know of examples and correct misconceptions – that is absolutely something the College will do. I would point to the Long Term Plan and the future-workforce plan as an opportunity to pivot away from some tactics that haven’t worked.

The issues of rest, hydration and availability of basic facilities are something I raise at every opportunity with government and national NHS leaders. In my mind this is the starting point to improve all doctors’ lives and is the urgent priority, as having greater control of rates is of limited value if your wellbeing is not provided for when you’re working.

SM: Obviously, there was a lot of contention surrounding the introduction of the new junior doctors contract, but what we have ended up with does include a number of components that are meant to ensure that we have a better experience – excepting repairing, personalised work schedules, among others. Is delivering these aspects of the contract something the College has been involved with?

RM: Our College Charter says we are here to educate and train our members and others. Is delivering these aspects of the College a role we have ended up with?

SM: I want to ask you about the expanding role of physicians’ assistants or anaesthesia (PAs), and how you would address any concerns that this might compete with the training opportunities available for those in the specialty training programme.

RM: It is a theoretical possibility that arises every time a new layer is added. We heard similar concerns when SAS doctors were introduced. With the demand we face, there is always room for highly skilled healthcare professionals at every level of our team. We need PAs to be regulated, and it looks as if that will happen. Making sure that we have the right training opportunities in place brings us full circle to our conversation about the new curriculum.

SM: It’s not just the clinical skills that are important to be a well-rounded doctor, but also the professional and managerial skills. I’m an ST7 now, and I feel that I have a solid skill set, but I’m less confident that I’ve developed the skills needed to run a list or coordinate with other teams within a hospital. Do you think the final years of training adequately prepare us for the whole scope of the role of consultant?

RM: With a competency-based clinical curriculum, we lost some focus on the professional skills you’ve mentioned, and one of the aims of the new outcomes-based curriculum is to bring that back. Some of it is to do with the split between clinical and teaching time. I think that this is too rigid, and that for trainees and anaesthetists in training the demarcation is unhelpful.

SM: I know from speaking to friends that there is a lot of variation from department to department in the level of autonomy and responsibility that registrars get...

RM: And that variation from place to place is natural, and one thing I want to communicate is the opportunities that perioperative medicine can offer to anaesthetists to get a more varied role, in which you spend more time supporting patients to get fit for their operation and fit after their surgery.

SM: Potentially, anaesthetists in training could find that the development of perioperative medicine offers more opportunities to get involved in a patient’s journey and influence patient care. It also gives us opportunities to help design and improve clinical and logistical pathways, so that we are giving our patients more effective care and, hopefully, making the system more efficient. This aligns with our ‘millennial’ aspirations to make the world, or at least the NHS, a better place.

[To bring the conversation to a close, the interviewer asked both Sarah and Ravi what one change they would make if they had a ‘Magic Wand’ for the NHS]

SM: I would like every department to introduce a ‘Lead for Humanity’ whose role is to make sure everyone was well rested, had time to eat and hydrate, take scheduled breaks and had been able to plan clinical commitments for the coming weeks alongside their life outside of work.

RM: I would ‘boundary bust’ wherever I could: between anaesthetic teams, and across all our specialties. I like Jo’s idea of a ‘Magic Wand’ for the NHS.

SM: I would like to see the delivery of primary care and secondary care, between surgical and anaesthetic teams, and across all our specialties. I like specialties, but I don’t like specialism where that makes you think about your own narrow area and not about the whole person.

* The interview was conducted on Monday 11 February 2019 at the College. Thanks to Sarah for her time and her department for allowing her the time away.

As ever, if you have any comments about this month’s President’s View, please do get in contact by emailing president@rcoa.ac.uk.
NEWS IN BRIEF

News and information from around the College

Advisory Appointments Committee News

The College is pleased to announce the appointment of Dr Ewen Forrest and Dr San Jaggar as joint leads for the College’s Advisory Appointments Committee (AAC) work stream. Dr Forrest has recently demitted as lead regional advisor for the College [2015-18], after many years of acting as regional advisor for Mersey. He is a consultant anaesthetist at the Countess of Chester Hospital in Liverpool. Dr Jaggar is a Training Programme Director for ST3-4 at the Imperial School of Anaesthesia, and is also deputy chair of the Primary FRCA for the College. She is a consultant anaesthetist at Royal Brompton Hospital.

Professor Bryn Baxendale discusses the merits of the College’s new Simulation Strategy

The College has recently released a digital recording of an interview with Professor Bryn Baxendale (Chair of the Simulation Working Group) discussing the launch of the new five year Simulation Strategy.

Simulation is a recognised method used to enhance education and training opportunities for the anaesthetic profession. It is also used to examine standards of practice, and ‘stress test’ the safety of existing or new systems and processes.

The simulation strategy aligns with key principles of the College’s overall strategic plan to support anaesthetists, improve standards in clinical practice, research and development. Please find further information about this strategy at bit.ly/RCoA-Simulation-Strategy and to listen to the interview with Professor Bryn Baxendale at bit.ly/RcASimulations.

Read more about simulation and multiprofessional crisis resource management (CRM) team training on page 52.

The College marks NHS Sustainability Day with the launch of its Sustainability Strategy

The College celebrated NHS Sustainability Day (21 March) with the launch of its Sustainability Strategy www.rcoa.ac.uk/sustainability-strategy. The vision for the College clearly states its commitment to embedding sustainability in everything it does and Council member, Dr Lucy Williams created a robust and comprehensive strategy to encompass this. The strategy outlines priorities, implementation and how the College’s Sustainability Strategy will be measured to ensure that achievements clearly align to the College’s vision.

NHS Sustainability Day celebrates the importance sustainable development plays within the UK’s national health services. The College undertook social media activity on NHS Sustainability Day not only to support how members celebrated but also to showcase the College’s strategy. In addition, a blog bit.ly/RCoA-Sustainability-Strategy written by Dr Lucy Williams was also released on the day which took a closer look at the aims of the Sustainability Strategy and why it was created.

The College is a founding partner of the UK Health Alliance on Climate Change (UKHACC) and worked with UKHACC to share messages about the College’s Sustainability Strategy and the blog to its network.

Anaesthetic CCT Curriculum Review 2020

Following publication of the General Medical Council document Excellence by design: standards for postgraduate curricula in 2017, the curricula for all medical specialties must be revised in line with these standards by 2020. The existing Anaesthetic Certificate of Completion of Training Curriculum was launched in 2010 following approximately a two-year development process. Various changes and additions have been made to it since that time, however a full, wholesale review of its clinical content has not been undertaken since it was first written.

All medical specialties must align their curricula to certain requirements including:

■ introducing generic professional capabilities
■ be structured around a limited number of ‘learning outcomes’- activities that describe the work of an independent clinician in each particular discipline

Further information and regular updates about the curriculum review on specially created webpages can be found at bit.ly/RCoA-Curriculum2020.

The 2020 Anaesthetic Curriculum must be fit for purpose for now and the future so your input and support will be vital to contributing to this review.

The Centre for Perioperative Care

The College to launch the Centre for Perioperative Care

During Anaesthesia 2019 on 20–22 May, College Council member, Professor Mike Grocott will launch the Centre for Perioperative Care (CPOC). He will outline how the College (along with partners) will develop a centre for perioperative care with its aim to facilitate closer and more effective cross-College and cross-organisation working on perioperative care for patient benefit.

The Anaesthesia 2019 programme incorporates many chances for attendees to get closer to the ideals for the centre. Talks by Professor Denny Levett discussing the benefits of health and fitness prior to and post surgery and Dr Chris Snowden discussing GIRFT, a clinician-led programme aimed at improving patient care by reducing unwarranted variation in service provision and clinical practice, will all help build a vision for the centre. The last day of Anaesthesia 2019 includes a panel discussion on the vision for perioperative care and those in attendance will be encouraged to ask questions about CPOC plans.

From a physical space within the College and working alongside the Royal College of Physicians, Royal College of Surgeons, Royal College of General Practitioners and others, CPOC will coordinate perioperative care initiatives across the health and social care landscape. Multidisciplinary working groups will be established in specific topic areas such as prehabilitation and post-operative care, which will inform the development of College and stakeholder initiatives.

Effective delivery of perioperative medicine within the UK will be achieved through regional coordination to augment national efforts. These will include building on the College’s existing network of perioperative leads and local networks as well as supporting multi-disciplinary regional education, training, quality improvement and research initiatives in conjunction with other specialties.

This is an exciting and ambitious project and we look forward to keeping you informed of developments in the coming months.
e-Learning is evolving

Our award winning e-Learning resource is evolving. Find all the latest BJA Education articles and MCQs to help with your study and gain CPD points.

The improved e-Learning resource offers an easier navigation experience with your study and gain CPD points.

In addition, the #FightFatigue Working Group were also honoured with the Humphry Davy award. Given to individuals or teams, for sustained contributions to the College.

The following team members were awarded:

- Dr J-P Lomas
- Dr Felicity Carcara
- Dr Emma Plunkett
- Ms Nicola Heard
- Dr Roonja McCrossan
- Professor Jasdeep Pandit
- Dr Nancy Redfern
- Dr Kathleen Ferguson
- Russell Ampiola
- Gavin Dallas
- Daniel Woelander

Latest news from the #FightFatigue Working Group

World Sleep Day (15 March 2019) marked one year since the launch of the national Fight Fatigue campaign, a joint initiative of the College, the Association of Anaesthetists and the Faculty of Intensive Care Medicine.

The campaign aims to raise awareness of the impact of fatigue and shift work on our NHS workforce. Despite growing support for the campaign there is still much to be done and fatigue continues to impact the health and wellbeing of those working in the NHS.

To celebrate the day, the team released a short animation across social media about the importance of getting enough sleep and the impact that sleep deprivation has on a person’s physical wellbeing.

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Guidelines for Provision of Anaesthetic Services 2019

The College is pleased to announce that the Guidelines for Provision of Anaesthetic Services 2019 (GPAS) have now been published. This is the first time that all chapters have been updated using our NICE accredited development process. NICE accreditation gives additional credibility to GPAS, providing independent assurance that the guidelines are robust and evidence based.

First published in 1994, GPAS is designed for anaesthetists with managerial responsibilities to set recommendations which inform how anaesthetic departments are run. Not only does GPAS shape the standards used by the Anaesthesia Clinical Services Accreditation (ACSA) scheme, but national regulators also recognise them.

We are always looking for ways to improve GPAS. In line with the College strategy on perioperative medicine and the establishment of the Centre for Perioperative Care (CPOC), in partnership with the Royal Colleges of Surgeons, GPs, Physicians and Nursing – GPAS work has begun on a new chapter for the perioperative care of elective and urgent care patients.

Guidelines for Provision of Anaesthetic Services 2019

The College is pleased to announce that the Guidelines for Provision of Anaesthetic Services 2019 (GPAS) have now been published. This is the first time that all chapters have been updated using our NICE accredited development process. NICE accreditation gives additional credibility to GPAS, providing independent assurance that the guidelines are robust and evidence based.

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Survey into Children’s Acute Abdomen Surgery

CASAP (Children’s Acute Surgical Abdominal Programme), the HSRC’s first paediatric initiative, is now running its organisational survey. Should your hospital be participating in this important pilot programme to characterise the type and quality of care being delivered to children undergoing emergency abdominal surgery (including appendectomy)?


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No doubt, most will be aware of the recent developments concerning fatigue, wellbeing and resilience in the anaesthetic and wider healthcare community. One of the first steps in recognising the prevalence of the problem among anaesthetists in training was the College’s morale and welfare survey, published in 2017. It worryingly identified that 61 per cent of anaesthetists in training felt the job had an adverse effect on their mental health, with all grades of training at significant risk of burnout. These results have since been echoed by the SWeAT study (Satisfaction and Wellbeing in Anaesthetic Training), with recent work being undertaken by the government-initiated Behavioural Insights Team, searching for focal process-level interventions.

While life as an anaesthetist in training can no doubt be challenging at times, this issue pays respect to that challenge and the improvement initiatives that have been undertaken, while taking the opportunity to celebrate the successes and excellence that have been achieved notwithstanding this. We will hear from anaesthetists in training from around the country who have led and achieved excellence nationally and internationally, as well as reflecting on the advances made in understanding our own limitations and supporting our specialty’s members. The themes of collaboration, camaraderie and teamwork are openly incorporated and (quite rightly!) embraced in the articles that follow.

It has been a record-breaking 18 months for research led by anaesthetists in training, and we will hear about both of the largest-ever consenting and non-consenting trials in anaesthesia to date – DALES (Drug Allergy Labels in the Elective Surgical population) and SNAP-2 (Second Sprint National Anaesthesia Project) respectively. Dr Laura Carrick will outline the power and reach of RAFT (Research and Audit Federation of Trainees) in enabling anaesthetists in training to be involved in high-quality research alongside their clinical training, in addition to discussing the innovation of a large-scale, digitally-run study. As his PhD draws to a close, Dr Danny Wong shares his reflections on the SNAP-2 study that has drawn the attention of the UK press in its observations on cancelled operations, and shares his thoughts on the infrastructure needed for successful research delivery.

Perioperative medicine has evolved to become a mainstay of the training curriculum, with rapidly expanding service development implications and interest as an area for specialist training. We begin by hearing from Drs Anas Zyada, Samantha Moore and Nicole Greenshields about the National Perioperative Medicine Roadshow, an innovative initiative to bring quality perioperative-medicine education to doctors in training around the country with the aim of progressing from London-centric national perioperative-medicine events. Continuing the theme, and recognising the need for education of the whole multidisciplinary team to effect change and the importance of safer surgery globally, I will then outline the global progress and success of the massive open online course (MOOC) ‘Perioperative Medicine in Action’. The developments that have been made in the last year in supporting wellbeing and resilience at work have been remarkable, and Dr Sally El-Ghazali closes the edition by celebrating the initiatives led by anaesthetists in training, while making a case for the transition to emotional intelligence.
THE PERIOPERATIVE MEDICINE ROADSHOW: RUNNING A NATIONAL EVENT

In 2018, TRIPOM (Trainees with an Interest in Perioperative Medicine) launched its national Perioperative Medicine Roadshow, an educational programme aiming to bring perioperative medicine to all training deaneries in the UK.

TRIPOM is an international society, based in the UK, providing access to free educational resources, events, and opportunities for publications in perioperative medicine. Established in 2016, it is run by and for doctors in training. It is a multidisciplinary collaborative of perioperative medicine enthusiasts with regional leads in each training deanery in the UK.

Why the need for a national Perioperative Medicine Roadshow?

Perioperative medicine (POM) is a core curriculum topic in anaesthetic training, as well as a mandatory element of both surgical and medical training. However, most national perioperative medicine courses and conferences with nationally reputed speakers are based in London, with limited study leave and budget, can make it difficult for those in training to attend.

TRIPOM therefore decided to create a mobile perioperative conference – the Roadshow – with the purpose of making POM education more easily available to doctors in training from all regions. With an educational grant from Edwards Life Sciences and the generosity of our speakers in giving up their time, we are able to provide a quality POM educational resource free of charge for attendees.

The Roadshow visits each training deanery in the UK (one every two months), offering a free POM education day mapped to the curriculum, a chance for POM-interested doctors to network with others in the field, and encouragement for cross-specialty collaboration. Didactic and interactive sessions are delivered by a number of nationally renowned and local POM specialists. Topics covered include intraoperative fluid management with haemodynamic simulation, enhanced recovery, perioperative anaemia, cardiopulmonary exercise testing, frailty, and the Perioperative Quality Improvement Programme. It has been prospectively awarded CPD points through the RCoA.

Roadshow success

At the time of going to press, the first two Roadshows have taken place in Swansea and Brighton in October and December 2018 respectively. These were attended by doctors in training of all disciplines, specialty doctors, consultants, medical students, and multidisciplinary team members. Events will also be taking place in Stoke and Oxford in February and April 2019.

A total of 149 people enrolled for the first two Roadshows, with 85 per cent stating afterwards that learning from the day will directly influence their clinical practice. We are grateful for the qualitative feedback from candidates, which has been overwhelmingly positive:

‘Excellent range of cross-specialty speakers’

‘Leaving feeling very energised re POM’

‘A fantastic event’

The Roadshow will be travelling to Bristol on the 3 June 2019, and free places can be booked online: http://bit.ly/2Eu0eLa Pending further funding, TRIPOM will continue the Roadshow into the latter half of 2019.

Reflections on running large events

What is needed to set up a national event? Resilience, proactivity and organisation! As anaesthetists we are high achievers, and therefore naturally feel the need to maintain the highest standards in all our endeavours. However, conventional training rarely offers the opportunity or experience to prepare for large-scale event planning, and so resilience and persistence are needed.

An enthusiastic and receptive group of individuals is vital to assure success, with the Roadshows allowing local teams to be involved in and part of their local events planning. Roles such as booking venues, arranging speakers, advertising, and administrative duties were completed as a team. The use of instant messaging and online document sharing allowed most of the planning to be done despite geographical separation, with regular instructions and updates to the local teams.

Despite the hard work and dedication needed to make the Roadshow a success, there is no doubting the sense of accomplishment and satisfaction it brings, especially when considering that it has been undertaken alongside clinical anaesthetic training.

Join us!

TRIPOM is free to join (all welcome), and provides a number of free resources via the website www.tripom.org. These include:

- details of fellowships in perioperative medicine
- Perioperative Medicine in a Nutshell – a series of short articles on key topics that are published in the British Journal of Hospital Medicine, written by TRIPOM members
- Perioperative Medicine Tutorial of the Month (POMTOM) – longer articles on interesting topics within perioperative medicine, accompanied by self-test MCQ’s.

We are running a breakout session at the Anaesthesia conference, 20–22 May 2019 www.rcspi.org.uk/anaesthesia, and an educationally focused day at the TRIPOM Annual Congress held at the British Museum on 3 July 2019 https://bit.ly/2EJbZ2y
RAFT AND THE POWER OF CITIZEN SCIENCE

On behalf of the RAFT committee and Trainee Research Network

Since the first trainee research network (TRN) was established in 2012, engagement with research by anaesthetists in training has grown to the extent that there are now 18 regional and 3 subspecialty TRNs – paediatrics (PATRN), pain (PAINTRAIN), and military (TriSTAR).

The TRNs provide all anaesthetists in training with the opportunity to engage in audit, quality improvement, and research projects. Harnessing the power of collaboration, the Research and Audit Federation of Trainees [RAFT] is an umbrella organisation that links the TRNs together.

RAFT has, to date, led three national projects: COMS (Cardiac Output Monitor Study – looking at the availability of cardiac output monitors and the impact of NICE guidance and Commissioning for Quality and Innovation (CQUIN) payment schemes), iHYPE (Intraoperative Hypotension in the Elderly), and most recently DALES (Drug Allergy Labels in the Elective Surgical population). Each project has been chosen, developed and led by anaesthetists in training, with each project relevant, topical, and aiming to achieve something meaningful for both patients and anaesthetists.

DALES has become the largest-ever consenting anaesthetic study in the UK, with recruitment across England, Northern Ireland, Scotland and Wales. 1,500 local investigators at 214 sites recruited 2,100 patients and 5,000 anaesthetists. As an NIHR portfolio study this large scale recruitment translated into significant financial gain in the form of accruals for each site. The project was also the first to utilise real-time secure data uploading online using REDCap software on such a large scale, demonstrating the feasibility of such a system and the digital potential for future large multicentre trials. Study results are expected to be shared and published later in 2019.

Impact for anaesthetists in training

A recent survey of TRN activity has revealed that all the TRNs have taken part in at least one NIHR portfolio study, proving that the aim to facilitate research within anaesthesia. For many, their involvement with their TRN has proved to be educational with the added benefit of meeting many of the Annex G requirements, and, significantly, this work is now receiving recognition by deanseries, with the work recognised at ARCPs.

A number of the TRNs have led educational meetings within their regions, providing relevant knowledge and promoting research within anaesthesia. Through this and through project activity, more anaesthetists in training than ever are completing their Good Clinical Practice training. For many, their involvement with their TRN has provided a pathway for becoming involved in national studies, which have all utilised collaboration to generate huge data sets, with the idea that such large numbers provide high-quality information. This is the underlying principle of citizen science, and the success of the NAPs and RAFT projects clearly demonstrates the power this has, as well as being something that is within everyone’s reach.

The achievements of the TRNs, both individually and collectively through RAFT, have developed research education and activity by anaesthetists in training to a new high level which has resulted in recognition by the RCoA, the AAGBI and the NIAA. This is all thanks to the hard work and sheer excellence of the anaesthetists involved.

References
1. RAFT (www.raftrainees.com)

Figure 1 Map of the TRNs throughout the UK. Details of the TRNs can be found on the RAFT website (www.raftrainees.com/member-research-networks.html).
Why perioperative medicine?

High-risk surgical patients are at significant risk of perioperative complications and death, and a call to make changes to care provision to improve their outcomes has been made globally.1,2 Perioperative medicine (POM) is the practice of multidisciplinary and integrated medical care that aims to optimise the clinical pathway of these patients by providing a clear care structure from the moment the patient is considered for surgery until they have fully recovered.3

Since its first inclusion in the training curriculum in 2015, supported by the RCoA vision document ‘The Pathway to Better Surgical Care’,1 POM has evolved to become a mainstream of anaesthetic training and service development. There is also significant interest from all levels and specialties of healthcare staff (doctors, nurses, pharmacists, physiotherapists) to learn more about how POM can improve patient outcomes. While there are courses in POM available, they all involve a not-insignificant enrolment fee, and are not openly available to all members of the team.

We wanted therefore to create a free, accessible online course on POM that was available and relevant to all members of the multidisciplinary team (MDT), no matter where in the world they were based.

Why a MOOC?

Online education has evolved from simple e-learning to something substantial enough to harness international education. The ultimate configuration of this is the Massive Open Online Course (MOOC). This is, exactly as the name suggests, hosted online, free to users, unlimited in the number of students, and globally available. A MOOC in POM was therefore exactly the platform needed to disseminate high-quality, free POM education around the world. Through a competitive process, a grant from University College London was secured, and a space on the MOOC platform, FutureLearn, acquired.

The ‘Perioperative Medicine in Action’ course was created, with definition of the course content beginning with a review of the current evidence base for POM, as well as seeking examples of outstanding perioperative care to encourage learning from excellence. The course structure was divided into four weeks (see Figure 1).

Delivery is in a number of short steps that take around 15 minutes to complete, and uses a variety of media – review articles, videos with experts, and polls for you to voice opinions and hear others from around the world. Contributions from more than 50 POM experts representing more than 30 institutions around the world are included, and social learning is encouraged in the course forums. The course was launched in 2016, and is run over a four-week period, three times a year. It takes roughly 2–3 hours per week to complete, and covers all of the clinical topics from basic, intermediate and higher POM curriculum modules – great for helping sign-off.

Achiving excellence

To date, the course has been accessed by more than 16,000 people in 140 countries. The majority of these are UK-based anaesthetists, but all members of the MDT are represented, as well as individuals from both high- and low-income countries. The course has been commended for its global reach, popularity (200,000 learning steps completed and 16,000 forum posts made), high completion rate, and high learner-retention index (0.475).

Qualitative analysis of post-course survey comments showed that learners thought the course was of ‘very high quality’, ‘beneficial to the MDT’, and ‘an outstanding innovative mode of education’. The course has had universally positive feedback from learners, with 84 per cent reporting that it will directly ‘improve their patient care’.

In such a fast-moving specialty, our main challenge has been to ensure that each course run is up to date with the latest evidence-based interventions, and incorporates improvements in response to learner feedback. Examples include new sections on perioperative anaemia and setting up intravenous iron services, how POM can improve care in emergency paediatric surgery, and an introduction to the Perioperative Quality Improvement Programme. The course also has a Spanish translation available to improve its global accessibility.

This is the first free and open access course on POM that is available to all members of the MDT, and in all countries of the world. It has broken both barriers in both reach and popularity. We are beyond proud that its quality and innovation has been recognised with formal endorsement from the Royal College of Anaesthetists, the World Federation of Anaesthesiologists, the Colombian Anaesthetic Society, and the International Board of Perioperative Medicine.

If you are interested in taking the course, then simply visit www.futurelearn.com/courses/perioperative-medicine, create a profile, and sign up for free. The next courses start on 1 July and 4 November 2019 – we look forward to ‘seeing’ you there!

A huge thank you and recognition to the work of Dr Abigail Whitman (current lead educator and course initiator), Dr Phil Sherrard (previous lead educator and course development), POM UCL team, the RCoA, and all other contributors for their input and support.

References
Reflections on SNAP-2 and collaborative research successes in the UK

Where has all the time gone? As I sit down and write this article, almost three years have passed since I first embarked on my time out of training to work on the second Sprint National Anaesthesia Project (SNAP-2), which many readers will no doubt have come across at some point in the last couple of years. Now, as I am preparing to return to training, it is a good time to take stock of what the project has achieved.

In the spring of 2017, frontline anaesthetists all over the NHS participated in data collection for SNAP-2, and since then we have published the first peer-reviewed article from the study in the British Journal of Anaesthesia (BJA). This generated significant public interest, with more than 2,900 collaborators across the UK listed on PubMed as collaborators. That work, describing the scale and reasons for surgical cancellations in the UK, was picked up by all the major newspapers in the UK and reported by many regional BBC radio stations. A second paper has also been accepted by the BJA, and this also includes data contributed by collaborators from Australia from their iteration of SNAP-2 Down Under, which describes and compares the critical care and high-acuity facilities available to postoperative patients in the UK, Australia and New Zealand. Findings from both these papers are likely to contribute significantly to future service planning to ensure the NHS can continue to deliver quality care to patients in the perioperative period. Source data from the second paper in particular is playing a central role in the intensive and critical care workstream for the Getting It Right First Time (GIRFT) programme.

The success of SNAP-2 is entirely the result of frontline contributions from working anaesthetists across the NHS, both consultants and anaesthetists in training, who provide high-quality data alongside the provision of high-quality patient care, often in the midst of significant difficulties that the NHS faces together with increased service demands. The UK anaesthetic research community now has a proven record of producing high-quality, impactful research projects such as the National Audit Projects and SNAPs, and other projects like iHypE and DALES led by anaesthetists in training. Our collective success has led to substantial international interest, with many colleagues around the world asking how we manage it and whether our research delivery model would work in their local contexts. I have written elsewhere about the factors that I think have been crucial to the delivery of collaborative multicentre research, but I would like to reiterate them here:

- Trainee research networks: there are now more than 20 trainee research networks spread out across various regions in the UK, coordinated by the Research and Audit Federation of Trainees (RAFT). The networks provide different regions of the UK with a way of coordinating research activities, and facilitate the delivery of larger projects that involve multiple hospitals. They are a powerful resource for crowdsourcing data, and are now serving as a model for research initiatives led by doctors in training in many other countries as well.
- Strong membership links with and through the Royal College of Anaesthetists and the Association of Anaesthetists: anaesthetists in the UK have an active social and collaborative engagement with the College and the Association. The strong sense of anaesthetic community means that the members of both organisations are often very motivated in participating in the activities of the group, and this principle of community runs all the way through in maintaining clinical standards, and fostering future anaesthetists through education and training, as well as improving knowledge through research.
- Post-fellowship training: for many other medical specialties, technical experiences acquired post-fellowship are a powerful resource for crowd-sourcing data, and are now serving as a model for research initiatives led by doctors in training in many other countries as well.
- Strong membership links with and through the Royal College of Anaesthetists and the Association of Anaesthetists: anaesthetists in the UK have an active social and collaborative engagement with the College and the Association. The strong sense of anaesthetic community means that the members of both organisations are often very motivated in participating in the activities of the group, and this principle of community runs all the way through in maintaining clinical standards, and fostering future anaesthetists through education and training, as well as improving knowledge through research.

I would like to take this opportunity to personally thank all the anaesthetists who have taken an interest in SNAP-2, and also thank them for their continued involvement in the National Audit Projects (NAPs) and SNAPs. More papers are planned from SNAP-2, and manuscripts are currently being prepared to provide answers to some of the other research questions which SNAP-2 was designed to answer. SNAP-2 has been an extremely informative study both for its findings about the structure and processes of postoperative critical care provision for patients undergoing surgery, and also for what it revealed about the enthusiasm and energy for delivering research that sits on the frontline of the NHS. Long may the latter continue!

References
2. Getting It Right First Time: intensive and critical care workstream. [https://gettingitrighthome.co.uk/GettingFirstTime/intensive-and-critical-care].
3. iHypE: Intraoperative hypotension in elderly people. [www.i-hype.org].
4. DALES: Drug Allergy Labels in the Elective Surgical population. [www.railness.org].
6. [www.railness.org].

Dr Danny Wong
Trainee Lead, SNAP-2
GROWING RESILIENCE AND EMOTIONAL INTELLIGENCE

Resilience is described as the capacity to maintain wellbeing, cope with working under pressure, and the ability to bounce back from setbacks effectively.

There has been increasing interest in resilience and resilience education, both within medical schools and the anaesthetists training programme. However, there appears to be selective criticism of this concept, as some feel that it does not matter how ‘resilient’ an individual is if they are not working in a culture of wellness. Most importantly, just because someone is labelled as ‘resilient’, it does not mean they do not need support, as without this they may feel not only overwhelmed but also professionally unfulfilled.

The natural progression for some, therefore, seems to be to turn towards the concept of emotional intelligence rather than resilience. While resilience forms an important component of it, emotional intelligence encompasses much more than this. It is defined as the ability to recognise our own feelings and those of others, for self-motivation, and for managing emotions well individually and in relationships. Understanding the root cause of our emotions and how to use them can help us effectively identify who we are and how we interact with others.

Emotional Intelligence became a popular subject to explore in the 1990s after the publication of the psychologist Daniel Goleman’s work. He found that while the qualities traditionally associated with leadership, such as intelligence, toughness, determination and vision, are required for success, they are insufficient on their own. Truly effective leaders are also distinguished by a high degree of emotional intelligence, which includes:

- self-awareness – knowing yourself and your own resources, instincts and actions
- self-regulation – managing your own state, impulses and reactions
- motivation – emotions and drivers that help towards achieving goals
- empathy – awareness of others’ feelings, needs and concerns
- social skills – ability to interact with others and get the desired response

Essentially, strong emotional intelligence and resilience helps us deal with adversity and failure without finding ourselves stuck in a rut. Growing in emotional resilience requires that we work towards greater self-knowledge. It is important, for example, that we learn to identify how we react in emotional situations, becoming aware of how we react when stressed helps us gain better control over those reactions.

Training and development

Teaching and training in emotional intelligence and wellbeing support have grown hugely in the last few years. The Association of Anaesthetists Trainee Committee have helped to develop and introduce the #CoffeeandaGas initiative. This is a wellbeing project in which we encourage anaesthetists in training, consultants and all theatre staff to take time out of a busy working day to come together and have a chat! Conversations are important to help us share our experiences and reduce stress levels. It has been a great success, with some departments running this regularly or during departmental induction. Resources to make your #CoffeeandaGas a big success can be found at: www.aagbi.org/professionals/wellness/coffee-and-pa

Another project led by doctors in training which promotes emotional intelligence is the #KnockItOut campaign. This is a joint venture between the RCoA and AAGBI, utilising the work done by the British Orthopaedic Trainee Association. It focuses on the importance of a positive workplace culture that is free from bullying, harassment and undermining behaviours. The initiative highlights the negative behaviours within an environment, and empowers individuals to speak up if they experience or witness unacceptable behaviours.

There are many schemes run by the Association of Anaesthetists and the Association of Anaesthetists Trainee Committee that can help develop and nurture emotional intelligence. One such project is the Association of Anaesthetists’ national mentoring scheme. This was set up to allow members to spend time with a trained mentor in their region to help establish their values and goals, and to explore what will help or hinder them in making changes. It enables mentees to achieve something they care about and bring about a positive change in their personal life or career. More information on this can be found at: www.aagbi.org/professionals/wellness/mentoring/aagbi-mentoring-scheme

Growing in emotional resilience requires that we work towards greater self-knowledge

Although some of these schemes outline help to promote resilience and emotional intelligence, it is important that these should not be used in isolation. Providing someone with the skills and the support to deal with stressful situations will only go so far, and may give the perception that if someone is struggling they are not ‘resilient’ enough. Therefore, while it is important to help people develop their emotional intelligence, this needs to be done in conjunction with improving the environmental factors that may be contributing and mitigating their impact.
In 2016, the FPM published core standards for pain-management services, including those for cancer pain, which were adopted into the CQC inspection framework from 2017. However, there has been no supporting guidance for NHS trusts or existing pain-management, oncology and palliative-care services on how an integrated service might be configured, how it might be commissioned, and what activities it should undertake.

This new, recently published guidance led by FPM collates existing publications into a pain service specification or framework for clinicians and commissioners. This is timely because of the importance to the public of pain associated with life-limiting disease, the evidence of under-treatment or poor access to care, the need to show evidence of better pain management in CQC inspections, and the need to meet updated commissioning requirements for Highly Specialist Pain Management Services.

The framework describes four levels of service provision, and is designed particularly to inform and stimulate delivery of Level 3 services in secondary care (Table 1). This is likely to have the greatest impact with least cost in relation to meeting the needs of patients with cancer and other life-limiting diseases. Closer integration of these specialties can result in more comprehensive pain assessment and a wider range of Level 3 and Level 4 services for patients, comprising pharmacological, interventional, rehabilitative, and psychological approaches. Although this will certainly benefit patients with more complex pain syndromes, it might also help those with less complex pain but who require more skilful balancing of analgesic medicines or access to other interventions.

Table 1 Four levels of service provision

<table>
<thead>
<tr>
<th>Level</th>
<th>Healthcare Group</th>
<th>Assessment</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All healthcare professionals</td>
<td>Recognition of pain</td>
<td>Effective information-giving and compassionate support</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screening for pain</td>
<td>Referral to oncology or palliative-care professional</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Initiation of conventional analgesia</td>
</tr>
<tr>
<td>2</td>
<td>All oncology and palliative-care physicians and advanced practitioners</td>
<td>Assessment of pain</td>
<td>Management and titration of conventional analgesia</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnosis of pain disorder</td>
<td>Support for self-management</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Referral to specialist pain management as required</td>
</tr>
<tr>
<td>3</td>
<td>Linked palliative care and specialist pain management in secondary-care settings</td>
<td>Diagnosis of complex pain syndromes</td>
<td>Management of complex analgesic combinations, including high-dose opioids</td>
</tr>
<tr>
<td></td>
<td>Consultant in pain medicine jointly working with consultant in palliative medicine, both with accredited training in pain management in cancer and other life-limiting diseases</td>
<td></td>
<td>Intervventional procedures of varying complexity depending on local skills and resources</td>
</tr>
<tr>
<td></td>
<td>Access via referral from primary or secondary care professionals</td>
<td></td>
<td>Support for self-management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Referral to adult highly specialist pain management as required</td>
</tr>
<tr>
<td>4</td>
<td>Adult highly specialist pain management in tertiary care settings</td>
<td>Diagnosis of complex pain syndromes</td>
<td>Intervventional procedures not available at local Level 3 and including some more complex procedures (eg, implanted intrathecal drug delivery systems, cordotomy, and other neurolytic procedures)</td>
</tr>
<tr>
<td></td>
<td>Specialist services across the UK with consultant teams in pain medicine and palliative medicine</td>
<td></td>
<td>Rehabilitative programmes</td>
</tr>
<tr>
<td></td>
<td>Access only via referral from Level 3 services</td>
<td></td>
<td>Managing distress or other behaviours suggestive of complex drug dependence</td>
</tr>
</tbody>
</table>

Faculty of Pain Medicine (FPM)

Framework to improve pain services for patients with cancer and other life-limiting diseases across the UK

The Faculty of Pain Medicine has led guidance that will encourage closer working between pain-medicine, palliative-medicine and oncology professionals to benefit patients with pain from cancer and other life-limiting diseases. This is a collaboration with the Association for Palliative Medicine, the Association of Cancer Physicians and the Faculty of Clinical Oncology.
Faculty of Intensive Care Medicine (FICM)

FICM curriculum update

Dr Tom Gallacher
Chair, FICM Training Assessment and Quality Committee

The Faculty of Intensive Care Medicine has had its Purpose Statement accepted by the General Medical Council with some minor conditions, and is now pushing ahead with the full curriculum rewrite to comply with the new standards set out in Excellence by design: standards for postgraduate curricula.

The curriculum working group has now drafted the 14 proposed intensive care medicine (ICM) High Level Learning Outcomes (HiLLOs) mapped from the existing ICM syllabus. Although we are required to rewrite the curriculum to comply with the new standards, there has been no change in the skills and competencies required to become a specialist in ICM. Therefore, the challenge is to ensure that all components of the current curriculum are included in the rewritten curriculum to ensure they meet the requirements of the respective partner specialties’ new curricula. This will also facilitate the transfer of acquired competencies between specialties should a doctor decide to change their career plans and train in a different but related specialty.

These have been constructive meetings, and the new HiLLOs in medicine and anaesthesia have now been agreed and will be submitted to the GMC when we submit our final proposed curriculum to the latter’s curriculum advisory group for approval. We intend to do this in the early part of 2020.

What you need to know about CPD in the Lifelong Learning platform

Work is progressing to incorporate CPD functionality into the Lifelong Learning platform.

This major project commenced in March 2019, although the features that are being developed had been informed by a number of previous stakeholder engagement activities, including a survey of users of the existing CPD Online Diary, an information day for existing and potential new CPD Assessors, and responses to Bulletin updates on this work.

While all members are strongly advised to check the Lifelong Learning FAQs on the College website at www.rcoa.ac.uk/node/28166, we would also draw your attention to the following key information about this important work.

A fully joined-up Lifelong Learning platform

Launched in August 2018, the Lifelong Learning platform currently comprises the anaesthetists in training e-Portfolio and clinical Logbook. The integration of CPD functionality will deliver a seamless experience, supporting members throughout their careers and helping meet their needs for revalidation.

System enhancements

The system enhancements will allow CPD Learners to link activities and events to the ‘Domains’ in the GMC’s Good Medical Practice. There will be a more intuitive way for recording CPD skills, and it will be possible to add ‘real-time’ reflections while attending a CPD-approved event. CPD Learners will also have full access to the Logbook. A PDF report of the CPD Learner’s completed CPD activities plus reflections will continue to be available to evidence this supporting information requirement.

Your user accounts

If you are a current user of the CPD Online Diary, you will be emailed when the Lifelong Learning platform is ready for use. This will be sent to the email address that you currently have in the CPD Online Diary. Anaesthetists in training using the Lifelong Learning platform will receive a prompt via the system when they are eligible to use CPD features.

Information in the current CPD Diary

As has been the case with the e-Portfolio, historic records from the CPD Online Diary will not be migrated into the Lifelong Learning platform. However both systems will run in parallel for 12 months from launch to assist users in downloading their documents, which in many cases will be just the CPD activity report.

We hope you will enjoy using the Lifelong Learning platform with added CPD functionality, and for any further information about it please contact lifelong@rcoa.ac.uk.
SAS and Specialty Doctors

RESILIENCE

Dr Lucy Williams
RCoA SAS Member of Council,
Great Western Hospital, Swindon

“The bamboo that bends is stronger than the oak that breaks”

Japanese proverb

Much has been written about medical burnout in the last few years, and there has been a burgeoning of resilience training and workshops in response. What is this all about and how might it involve you?

Burnout can result in exhaustion, depersonalisation, cynicism and feelings of uselessness at work. Fatigue from shift working and poor sleep can be a major contributor. The College, Association and FICM have been working hard to understand this better with a series of fatigue surveys. As I write, the SAS survey is live and I hope that you will contribute. You can find educational material on the Association website. You can find educational material on the Association website.

The infamous NHS winter pressures now seem to last most of the year, and all staff in healthcare have to deal with emotionally demanding work. What can we do to protect ourselves from burnout? Hopefully your employer is providing appropriate rest and catering facilities, but you don’t have much control over this.

Most resilience workshops focus on steps we can take as individuals to protect ourselves from the potential harm of our work. In the south west, the deanery has run sessions specifically for SAS doctors, and these have been well received. Participants really valued the safe space in which to share and reflect on their own experiences. They were often surprised to find that their feelings were shared by others across all specialties. Look for similar opportunities near you, as well as sessions at national events.

A fundamental concept in developing resilience is that of self-care and self-compassion. Doctors generally set themselves high standards, and can be very self-critical. None of us is perfect, and learning to accept that is a step on the way to improved mental wellbeing. We cannot care well for others if we do not look after ourselves. It can be difficult to leave work behind at the end of the day, but try to commit to engaging with family and valued activities when you arrive home. You also need to eat and drink when working – make the time!

Understanding oneself means you can identify areas that need nurturing and developing. There are many self-help books. A popular one is The 7 habits of highly effective people, which is not just about being more effective at work, but actually looks at life in its widest sense. A balance must be achieved between work, personal, and family life. Where that balance lies can vary through life and will be very individual, but you are the only person who can identify when things are not right. Is it temporary or do you need to make some adjustments? The RCoA SAS survey of anaesthetists showed that a significant proportion choose SAS grades for a better work–life balance.

Identifying what is important to you can help in making sensible decisions about work–life balance. Sometimes you may be at a bit of a decision point, and unsure of the direction to take. Coaching or mentoring can assist. In training to do either of these, you learn more about yourself than anything else. Look for a colleague along the training – they will want people to practice on. Alternatively, check with your post graduate education lead or SAS tutor for advice. There may be a formal hospital system in place of which you were unaware.

Good relationships reinforce personal resilience. An SAS anaesthetist can spend a lot of time working as a solo anaesthetist. One of the joys of theatre working is building relationships with other professionals, especially operating department practitioners and anaesthetic nurses. They can be hugely supportive and many a heart-to-heart takes place at the head-end during long cases.

Being kind to others makes us happier. If you feel your workplace is not kind and supportive, be the change you want to see. Give your colleague a tea break if your list has finished early, buy someone a coffee, bake a cake (I see a food theme emerging here!). Saying something nice to someone a coffee, bake a cake. Sometimes you can irritate when people fail to thank us. Niceness is catching and poor behaviour can irritate when people fail to thank us. Niceness is catching and poor behaviour can irritate when people fail to thank us. Sometimes life is tough, and talking can help to get things in perspective. Hopefully, you have a trusted colleague or family member. If you feel isolated, there are other options. You can access occupational health services, or there may be more specific staff wellbeing services. These are often not well publicised within hospitals, so ask. You may prefer to look outside work using formal channels such as your GP or local ‘talking therapies’. Resilience is not an all or nothing concept. It is about more than your mental health – it encompasses a much wider spectrum of wellbeing and coping strategies for life, with all its ups and downs. There is always somewhere to turn if you need support.

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We cannot care well for others if we do not look after ourselves.
Problems with mental health and stress appear to be this season’s colours. They are raised in our papers, in our television programmes, and on the radio. Are we all turning into snowflakes, or are we being overwhelmed by forces beyond our control? In a world of increasing uncertainty (and the unmentionable B word!) we seem to have plenty to worry about. Some may think we have always had worries, so why is this different now? Some of it may be due to the way we work and live. Bit by bit we have eroded our face-to-face social contacts, and the key means of communication is increasingly by social media. For example, the loss of the ‘firm’ in hospital medicine and new ways of working may give a better experience, but does it offer good support to F1 and F2 doctors? Do they feel part of a ‘family’ or just tossed upon the waters? Adam Kay, author of ‘This is Going to Hurt’, noted on Radio 4 that a crisis number was prominently displayed in the dressing room of the London theatre where his show was being performed. He wondered why there was no such thing in the NHS? I know the College has support mechanisms and resources, but do we really advertise them extensively?

Stress can be useful. It’s the impetus to get things done, like writing this at the eleventh hour! However, in excess our state of wellbeing deteriorates. One suggestion is a daily check of oneself. Ask yourself: ‘How do I feel? Where’s my thinking going?’ One means of grounding oneself is the ‘5-4-3-2-1’ exercise, which involves thinking of five things you can see, four things you can hear, three things you can feel, two you can smell, and one you can taste. That should bring you to the here and now. Additionally, try to avoid using social media first thing on waking, as a negative response can alter your day. I often hear retired people comment on how busy they are to the point that they do not know how they had time to work! I find this odd because the point of being retired is that you can choose how to spend your time, and if you are that busy, well you opted to be so. Is our work ethic so well entrenched that we cannot live without it? We like to be useful and help where we can. However, we all need some time out for ourselves, whether it’s five minutes on the bed, reading for pleasure, listening to music or phoning a friend. Let us try and be kinder to one another and, more importantly, to ourselves.

Patient Perspective

How are your stress levels?

Carol Pellowe
Chair, RCoA Lay Committee

Problems with mental health and stress appear to be this season’s colours. They are raised in our papers, in our television programmes, and on the radio. Are we all turning into snowflakes, or are we being overwhelmed by forces beyond our control? In a world of increasing uncertainty (and the unmentionable B word!) we seem to have plenty to worry about. Some may think we have always had worries, so why is this different now?
More than half of departments across the UK are working towards ACSA. From previous articles, it is clear that collective will is required to engage in a process that can take several years of preparation. This article differs from others as we look specifically at how we, as a group of higher trainees, were able to help and influence Nottingham University Hospitals NHS Trust (NUH) in their desire to gain accreditation.

**Why get trainees involved?**
ACSA aims to assess and review the provision of anaesthetic services in all locations across a trust. Trainees are the continuum throughout 24-hour anaesthetic care, and are involved in the majority, if not all, of the areas where anaesthetic services are required. For this reason, we are uniquely placed to give an overview. Additionally, there are a number of trainee domains within the ACSA standards. Through peer review and audit, the process provides an excellent opportunity to engage with management at both departmental and trust level, enabling positive change for future trainees rotating through our trust. From a trainee point of view, it provides invaluable experience in quality improvement and management, especially for those in advanced training or approaching CCT. Being actively involved with many stages of a department’s ACSA bid reveals a lot about NHS management structures, and this improved our understanding of the hurdles that have to be jumped to bring quality improvement initiatives to fruition.

**What were our roles?**
Initially we focused on the trainee areas, conducting surveys on supervision, ease of access to consultant advice, and support in solo training lists. We looked at rest facilities for on-calls and at how well the on-call bleep and phone systems worked. The availability of Wi-Fi, especially in a Victorian era hospital building, was shown to have implications with regard to consultant-trainee communication in remote sites. This led to the building of a business case for IT services to improve coverage within the trust. As the process evolved, we analysed complex patient pathways, including those for patients with obstructive sleep apnoea and for the follow-up of patients with complex postoperative needs. NUH is a dual-site tertiary major trauma centre. Collecting demographic data on the number of cases anaesthetists are involved with and on staffing levels was an incredibly complicated task that gave us all a greater understanding of the medical-data-recording systems used within our trust.

**What did we learn?**
Having been involved with the process for a year, our team took tremendous pride in presenting our department to the visiting ACSA review team. Being a large and dual-site tertiary centre, it was impossible to be aware of all the incredible projects, services and processes that are in place to improve patient care within our trust; ACSA has allowed us to bring all of these to the forefront and showcase them. The process provided reassurance to the department in terms of the service we currently provide, but also gave us a determination to act on standards that still require attention. As higher trainees, we are involved in the majority of the clinical activities that take place in our trust. However, from a departmental perspective, there were still many things happening that we were not aware of. It was eye opening and interesting to meet key people in the management structure who had previously just been names at inductions. Building on these relationships played an important role in implementing change.

**Summary**
Being involved in our department’s ACSA bid as trainee representatives has been hard work, yet it was an enjoyable and extremely productive task. The process has increased our understanding of the management structure of our department, and helped us build the skills to enable us to become effective and productive future consultant colleagues. We would encourage other trainees to get involved in their departments’ bids; it may surprise you how much you will learn and get out of it! All that remains is for us to complete the last few remaining standards, and then hopefully achieve accreditation and receive our plaque!
Technology Strategy Programme (TSP)

Technology Strategy Programme update

In the January Bulletin, Michael King (Digital Project Manager) and myself focused on the two big remaining projects on the programme: the new website and the new membership management system. This time I will give you a round-up of how the other projects are going, and do a bit of reflection on what has recently been achieved.

I’m delighted to report that work on adding CPD functions to the Lifelong Learning platform began in January. The Training team have an intense two-month development phase, during which they will be working with our supplier and College members to define how the system will work, to build it, and to test the results. Adding CPD will complete the trio of functions the platform offers, and really deliver on the ‘Lifelong’ aspect of the platform. Read more about these exciting changes on page 27 with Chris ‘Mr CPD’ Kennedy’s update. Lastly, I’m pleased to report that, at the time of writing, work has begun on making the Logbook aspect of Lifelong Learning work offline for when you have no Wi-Fi signal.

At the other end of the Lifelong timeline, I can report rapid progress by the Exams team on their work to find a new system that not only manages their exams administration but also offers the provision of online exams. The team have done a great job of defining the need and working with potential suppliers, which has resulted in them identifying two good candidates for this area. The team and TSP members will now put the two finalists through their paces via a hands-on systems-development workshop with both.

In the area of Training, Exams and Events, I am pleased to reflect on the Exams team’s achievement in going live with their new EventsForce booking platform. Not only does this give a much more modern and much easier user experience for our members, it also offers real reductions in the time and complexity the team have historically had to contend with in running the old events-booking system. Having proven the value of the new platform, I’m pleased to report that the Exams team will also be moving to EventsForce for their bookings in the summer.

Another project to report on is ‘Document Collaboration’, which went live in December 2018. This is the College’s new system for sharing and collaboration on documents with multiple external people, sometimes in realtime. Now, this may not sound as transformative as, for example, a new member portal, but it does solidly address two areas where you as a subs, paying member should have an interest: College efficiency and security.

In the past, for example, a research document may have gone to 10 people as an email attachment for consultation, with Research team staff then having to collate 10 sets of comments and amendments, and then circulate the amended document again for another round of 10 sets of comments and amendments, etc. Now a single document can be shared from its online location, and people can collaborate on it and see the changes as they are added much more efficiently. In the past those 10 people may have left various versions of this document saved locally on their home or work devices, but now there is just one copy stored on a platform with the strongest data-protection standards – much more secure.

I want to move on now from individual projects to workstreams. The Technology Strategy Programme is made up of 32 separate projects grouped into seven workstreams, and while each project delivers a new system or way of working, it is the completion of each integrated workstream that generates the real value. Think about the individual roles health professionals play when, for example, a person needs surgery: the GP, the nurse, the porter, the anaesthetist, the surgeon; the GP again – these are the projects. But the overall experience and life improvement for the patient through them acting together – the perioperative experience if you like, that is the workstream creating value as a whole. As we move into the latter part of the programme we are starting to see this workstream value being realised as more than the sum of each project’s parts.

I mentioned the Document Collaboration project, and this is one of about seven projects that make up the ‘Infrastructure’ workstream. By the time you read this the workstream will be complete. So far it has delivered Unified Commos (the new phone and conference system), cloud-based email, Documentation Collaboration, College network improvements, and new security tools. The last piece of the puzzle is a suite of new servers at Churchill House. Together as a package these changes have transformed how we store information, communicate with each other, work remotely, collaborate, stay secure against ever increasing cyber threats, and ensure our business operations are protected.

Admittedly these changes will be felt mostly by staff and those members with College roles, but they are solidly supporting one of your organisation’s current five strategic aims: ‘Resourcing the Future of Anaesthesia’. The next big area of workstream value to arrive, however, will be all about the member experience: the coming together of the new website, member portal, single sign-on, offline working, and CPD. I can’t wait!

While each project delivers a new system or way of working, it is the completion of each integrated workstream which generates the real value.
DROP A DAY’S WORK – AND LOSE NO PAY?

On (not) meeting workforce challenges in anaesthetic departments

First, how many anaesthetists does it take to change a light bulb? In theory, no anaesthetic department should ever be short-staffed, because accurate estimations of staffing requirements are well-established in standard texts on operating-room management.1

For small departments, individual details can be collected, but for large departments, median estimates work equally well. First, assess the median direct-care component (DCC) within job plans (separately for consultants and SAS doctors). Then estimate leave entitlements (factoring in an amount for sick leave) and allow for everyone to take leave over the year while having sufficient staff present. Then, assess the average under-staffs and seeks to make existing staff work harder for the same pay. This can be achieved by some or all of:

■ reducing the supporting professional activity (SPA) allocations in job plans in various ways.
■ reducing or abolishing DCC time for perioperative care
■ curtailing or abolishing preoperative assessment clinics and pain-service rounds
■ curtailing annual leave by increased bureaucracy, requiring leave to be taken at fixed times, and abolishing carry-over of leave across years
■ restricting study leave funding
■ abolishing professional leave
■ maximising trainee service in exchange for training.1

In response, individuals affected may use the appeals process or tribunals, or actively reduce working hours, or become disengaged and concentrate instead on private practice (and/or, anaesthetists in training may be removed from the department). So the aggregate effect may be that little or no extra work results and staffing shortfalls remain.

Second: understanding the income death zone

It may be too much to hope for mature approaches to job planning and workforce calculations. Yet there is a latent, stronger force at work, limiting our ability to solve staffing shortfalls. Detailed analysis has already explained how government tax and pension changes logically mean that fewer anaesthetists will offer spare capacity to the NHS.1,2 Yet my lectures on this have been met with disbelief. Yes what I say makes sense, but how can government policy ever actively disincentivise NHS work? Figure 1 will therefore induce, for some, a Damascene conversion. It does not originate from a lone crackpot (like me), but from the Senior Salaries Review Body, recently presented to Parliament by the prime minister herself.2 Calculations, based on civil servants and the armed forces, apply to all public sector workers, including doctors.

The ‘income death zone’ is wide: gross salary ~ £105K–£165K, across which net income stays constant. Thus someone who earns about £105K through a mix of base income and clinical excellence awards, and who chooses to devote, say, two programmed activities (PAs) to additional NHS work, and perhaps diligently works annually in 20 extra weekend waiting-list initiatives, will take their total salary to say ~ £140K. The graph shows they need not have bothered. Their take-home pay remains the same, despite hundreds of hours of extra work, at ~ £140K as it was before. They might as well have played golf.

From a different angle, someone who is already anywhere within this ‘death zone’ might realise a strong incentive to drop an extra day’s work (or more, depending on exactly where they sit within the zone) and find they lose not a penny in take-home pay. They are then – literally from their perspective – being paid to play golf.

Conclusions

NHS planners hope that, despite Figure 1 emanating directly from government, most readers will continue to disbelieve the realities and remain in the ‘death zone’, passively working in the ignorance of heavily taxed extra sessions, to the end of their days. Some readers will in fact enjoy this work so much that they are prepared literally, to work for nothing. Other readers will take professional advice and seek various ways out of the zone. Some, by declining additional NHS work or some, by actively dropping NHS sessions and enjoying the free time released. Since income from private practice can also land one in the ‘death zone’, the attraction of invoicing via a limited company but not drawing income, may appeal to others. Leaving the NHS pension scheme, as explained elsewhere,3 will allow others to break free (ie, the green and red areas in Figure 1 then become net income). None of these options help meet the NHS staffing shortfall, which was the initial focus of this article.

References


FEEDBACK: GOOGLE FORMS AND QR CODES

The system for obtaining anonymised feedback from trainees regarding their educational experience with consultants on training lists, which uses a Google form linked to a QR code, was brought to us by Dr Fiona Martin. The Google form uses specific domains to evaluate the quality of the trainee’s educational experience. A trainee can access the form by scanning the consultant’s unique QR code (QR Code 1), and this leads to the form at https://bit.ly/2SL7sPA.

We have configured the same system for the trainee to obtain feedback on their performance following any educational interaction with a consultant (theatre or the emergency department). Each trainee is given a QR code at the start of their placement. They are also asked to submit a profile of themselves which includes details of their current training level, their direction of travel from a career perspective, and their preferred learning style. The profiles of all the trainees are then circulated to the consultants. The QR code for the individual trainee appears next to their picture in the profile document. We have in addition provided the trainees with profiles of the consultants in the department. The profile has the details of the consultant’s special interests, their contact details, and a picture of the consultant with their personal QR code. We have had feedback that the trainees find the system of providing profiles of the consultants in electronic format useful in easing the potential discomfort of being a new trainee in a large department.

Our department consists of more than 70 consultants, and we often have more than 30 trainees circulating within the department at any point in time. Thus there is a low probability of a trainee interacting with the same consultant more than once, and this makes it more important to collect feedback in a contemporaneous, objective fashion, rather than rely on the consultant’s subjective memory when it comes to the end of the placement.

Consultant feedback is mandatory with regards to Completion of Units of Training forms. Historically, our experience has been that consultants tend to feed back on aspects of the trainee’s personality, which is often influenced by the personal interaction between the consultant and a trainee, rather than providing feedback on the trainee’s ability to self-regulate or on their task performance. The purpose of feedback is often forgotten – it is not to make people feel better, it is to help them do better.

The Google form that we have devised and which can be found at: https://bit.ly/2RFb74n is populated by the trainees into a single document, produce the QR codes, and circulate the document amongst the consultants. Each trainee has an educational supervisor, and the feedback generated from the QR code system is delivered on a monthly basis to the educational supervisor as an Excel spreadsheet or in graphical form, to be discussed with the trainee at their regular educational supervisory meeting.

We had some teething problems with the use of the QR code system, as the consultants had become accustomed to the form that had been sent around at the end of a placement. The uptake of the QR code system was initially low, but has increased as the system has embedded itself into the educational culture of the department. Our experience has been that the volume of QR code feedback obtained is an indicator of performance. Trainees in difficulty avoid using the system, and sometimes the popular trainee who gets on with everyone also avoids the system. The system therefore facilitates remote monitoring of progress of trainees by the College tutors. We have found that the feedback has allowed us to more effectively assess trainees in difficulty, and to implement educational interventions in a specific and timely fashion.

Dr Fiona Martin, ST7 Anaesthetist, Northwest School of Anaesthesia

QR Code 1
Scan the QR code or use the link below https://bit.ly/2SL7sPA

QR Code 2
Scan the QR code or use the link below https://bit.ly/2RFb74n
In 1955, the World Federation of Societies of Anaesthesiologists (WFSA) was set up at the end of the first World Congress of Anaesthesiologists (WCA). Over the next 60 years the WFSA has grown to cover almost every country and to hold WCAs every four years.

Anaesthesia has made huge leaps forward since the mid-1950s. There is now safer and more sophisticated apparatus for the delivery of anaesthesia; drugs have improved in quality, safety, and efficacy; and education and training are at an all-time high. But these developments are mainly limited to the affluent world, and in the less affluent world patients lack even the most basic opportunities to experience safe anaesthesia and surgery for life-changing procedures.

The Lancet Commission on Global Surgery reported in April 2015, and highlighted the fact that in a world population of seven billion, five billion were unable to receive safe surgical or anaesthetic care. These were staggering results and remain totally unacceptable.

Basic anaesthesia and surgery have long been regarded as expensive luxuries by less affluent countries, but in 2015 the World Bank published the 3rd Edition of Disease Control Priorities which showed things from a different point of view. They concluded that for every $1 invested in safe surgery and anaesthesia there was a $10 return as those judged as sick and dying on the economy returned to work.

The WFSA has sought to improve anaesthesia provision worldwide its inception. It has published books and manuals, it has provided lecturers to many countries, and has encouraged meetings and communication. Now specific Training Centres have been set up where anaesthetists go to learn relevant techniques that they can take home and then teach locally – this became the Fellowship programme. Changes increased from 2012 onwards when the organisation appointed a highly qualified Chief Executive Officer, Julian Gore-Booth, who had a long track record of working in the

The Fellowship programme is one of many activities of this new WFSA (all activity can be seen on www.wfsahq.org), but it can only be maintained by donations. The Fellowship Training Programme is delivered at no cost to the fellow and is run by local volunteers. All of the money raised for the Fellowship programme goes to the travel and living expenses of the fellow.

The Fellowship programme works well. Individual anaesthetists are trained in a geographically ‘nearby’ hospital and then return home to work and teach and spread their new knowledge. The WFSA now has 52 fellowships as shown in Figure 1.

The recently published experiences of one such fellow is shown here.

Dr Luz Marina Sotelo completed the CLASA-WFSA Pain Management Fellowship in Buenos Aires, Argentina, from 21 May to 31 July 2018. She wrote that ‘[n]o matter what speciality we are in, pain is an integral part of our patients’ experience. The fellowship in Buenos Aires gave me the chance to learn and improve my technique in pain management. Under the guidance of the local anaesthesiologists and the help of the WFSA, we were able to learn the different procedures performed in pain management with the help of ultrasound and fluoroscopy for a better approach of interventionalism. We learned how we should prepare a patient from the preoperative stage to the whole procedure by means of protocols and algorithms already established in each hospital.

Of the many skills and the knowledge that Luz gained during her fellowship, she notes that she is now able to perform acute and chronic pain-management protocols, leading to improved care for her patients. Following her fellowship, Luz returned to Peru and prepared a conference to replicate the activities she did during her fellowship, which benefited a further 20 to 30 assistant anaesthetists and 25 specialty anaesthesiology residents.

Luz comments that ‘the patient will be the biggest beneficiary as they will receive better attention and gain a better quality of life’.

As a long-term supporter of the Fellowship programme and donor to ‘Fund a Fellow’, I would like to ask you to donate towards this programme. This can be done as an individual or as a department. It can be a one-off or an annual donation; all of which can benefit from Gift Aid as you are donating to a UK Charity (WFSA UK), which in turn supports WFSA. If you go to the WFSA website then you can follow the simple instructions to donate: go to https://safetysurgerycharitycheckout.co.uk/WFSA and fill in the form.

At present, four times as many people die every year from conditions that could be treated by surgery and anaesthesia as die from HIV, malaria and tuberculosis combined. Please do something to help WFSA change this; tell other people about this unacceptable situation and donate to change it.

Figure 1 Fellowship Training Programmes

Dr David J Wilkinson
Past President WFSA, Trustee WFSA UK
PAIN MEDICINE TRAINING
Reaching out to the developing world

Understanding pain has been one of the oldest challenges in the history of medicine. The European Federation of the International Association for the Study of Pain (IASP) declared that chronic and recurrent pain is a specific healthcare problem and a disease in its own right.

According to a 2014 global study on the global burden of chronic pain, at least 10 per cent of the world’s population is affected by a chronic pain condition, and every year, an additional 1 in 10 people develops chronic pain. Chronic pain is a disabling condition, and, as reported by Turk et al., affects every aspect of a patient’s life, contributing to a loss of physical and emotional function.

Inadequate chronic-pain management may be related to the inherent challenges of treating chronic pain, insufficient consideration given to common co-morbidities, concerns about dependence, and addiction. But, more importantly, it can be due to lack of training for chronic pain management in medical school and residency programmes, and a lack of educational resources. Consequently it is unsurprising that providers report low satisfaction and lack of confidence in treating chronic pain. Despite the high prevalence and public health burden of pain, pain education is considered a non-essential part of undergraduate medical education across Europe.

Postgraduate specialist pain training in the UK takes place within the anaesthetic curriculum, and consists of two mandatory modules (basic and intermediate) and two optional modules (higher and advanced). Strongly committed trainees embarking on a career in pain medicine undertake an advanced year, and usually spend this in a single tertiary pain centre, or in a number of units each offering different educational opportunities. The fellowship exam was established in 2012; it covers both practical and clinical knowledge and knowledge of relevant sciences, and has the aim of enhancing the practice of pain medicine in the UK. The Faculty has submitted a draft document to the GMC for consideration of piloting pain medicine as one of its first credentials.

While enthusiasm for pain education and clinical training in developing countries has grown, restrictions by governments and health administrations have represented a significant barrier. The Royal College of Anaesthetists offers training opportunities for anaesthetists from low-income and lower-middle-income countries via the Medical Training Initiative (MTI). The scheme provides a route for high-quality international medical graduates to obtain sponsorship, for their GMC registration and also sponsorship for Tier 5 visa, which will allow them to undertake a training placement in a UK hospital for a maximum period of 24 months. There are many opportunities for pain medicine under this scheme, and the Faculty of Pain Medicine would encourage interested trainees to apply. Further information can be found on the College website at http://RCoAAMTI.org.

The College offers training opportunities for anaesthetists from low-income and lower-middle-income countries via the Medical Training Initiative

References
Quality improvement book - recipes for success

The 3rd edition of Raising the standard: a compendium of audit recipes better known as the ‘Audit recipe book’ was published back in 2012.¹ The last edition sought to bridge the gap between audit and quality improvement (QI) and to provide practical guidance on how to use QI to act on audit findings. Since the last edition, there is much greater awareness of implementation and quality improvement science both within the specialty and healthcare as a whole, but many of us still have limited experience of ‘real-life’ practices of improvement.

When the topic of QI comes up, inevitably some will ask ‘what should I do and how do I do it?’ There are many reasons why we should all learn how to do improvement work and understand the basic QI tools. Quality improvement provides us with the means to influence the environment in which we practise, to tackle waste, harm and unwarranted variation in our system. In addition the need to improve delivery of person-centred care is a core value for all health professionals. This is specifically reflected by the GMC in their Generic Professional Capabilities Framework for training and continued professional development.¹⁻²

· Royal Colleges through their Quality improvement training for better outcomes document.²⁻³ This recognition is also reflected within the RCoA strategy – that good quality QI learning and delivery needs to be actively supported.

· The modern NHS requires improved efficiency and effectiveness, despite limited resources and on the background of an ageing population with increasingly complex health needs. It is we, the frontline staff who deliver care every day and understand these challenges, who need to make the improvement of care a core daily activity. Our patients and NHS as a whole depend on us for the delivery of safe, reliable and effective care. The initial approach to improving care within the healthcare systems was to focus on reducing errors and audit. Both error reduction and audit are essential but we need to take further steps to make sustained changes in behaviour. In order to make viable and long-term improvements we need to transform the systems that we work in.

· So what do we need in order to improve? There is an enormous amount of information out there on improvement science, different methodologies and skills; however, better skills and knowledge alone do not always equal improvement. QI is about having the attitude, skills and will to make things better. The Health Foundation’s – The habits of an improver, emphasises that if we are to make meaningful and lasting improvements, we should adopt a number of QI ‘habits’, such as being empathetic, optimistic and a team player.²⁻³ Only when we change our behaviours, will QI be the ‘norm’. We all know that getting people to change can be very complex but seemingly small behavioural changes can have a ripple effect in healthcare. As anaesthetists, we have always been early adopters of various innovations and forerunners in initiating changes, advocating for improved patient experience and safety. So make a point of starting – find something that you want to improve, start with some easy wins and keep going. Don’t let what you can’t change put you off doing things that you can.

The forthcoming edition of the QI recipe book will provide a resource to support the QI agenda in anaesthetic departments and to encourage teaching, training and continued professional development in QI. The book covers a wide range of subject areas in anaesthesia and perioperative medicine, as well as wider issues affecting our practice. Inclusion of ‘real-life’ examples will describe different approaches and enable the user to put content into practice. Experts and specialist societies contributing to this edition have identified important themes facing us now and also in the longer term. We are confident that this will be a good starting point for all to improve the patient journey and outcomes. Each recipe is mapped onto curriculum, CPD matrix and ACSA standards to allow departments to focus on particular standards and ultimately facilitate delivery of GPAS and entry into ACSA.

Finally, the anticipation is that this resource will provide meaningful examples of change, and encourage anaesthetists to look at their own department/hospital practices and inspire them to lead that change. For anaesthetists in training this is will allow them to become intimately involved in shaping hospital systems and lead to lifelong adoption of QI methodology, while in the long run improving patient experience, outcomes and their own job satisfaction.

References:
1. Raising the standard: a compendium of audit recipes better known as the ‘Audit recipe book’ was published back in 2012.¹
The Multidisciplinary Team in Action: applying perioperative medicine to the high-risk surgical cancer patient

As a specialist cancer centre, the Royal Marsden Hospital (RMH) undertakes approximately 4,000 major to major/complex surgical procedures per year, and patient selection and optimisation is a key factor for a successful outcome. At RMH we have looked at cancer patients presenting for major surgery over a four-year period, and we have seen a significant increase in age, frailty, and co-morbidity.1

Quite often these are palliative/end-of-life patients presenting for surgery to aid symptom management and improve quality of life. Increasingly, patients are being referred to us who have been turned down by other centres, typically because of the complexity of their cases. This group will therefore have an increased risk of requiring significant organ support, of long term functional disability, and of mortality. Surgery in this patient population requires significant resources during the perioperative period. The application of perioperative medicine to this group is vital, and from our experience the process of shared decision-making is integral to ensuring these patients get the very best outcome.

Personnel involved
The High-Risk Surgical Patient CCU MDT at the Royal Marsden Hospital is led by five or six critical care physicians, with discussion and input from various specialties that are vital to delivering care to these patients. These include surgeons, physiotherapists, occupational therapists, dieticians, clinical nurse specialists, and our senior critical care nursing teams.

The MDT approach in decision-making in high-risk cancer surgery enables more effective communication between team members, allowing the identification of potential problems by bringing together the full knowledge of each professional. During this process any potential areas for optimisation are highlighted preoperatively. The most appropriate mode of surgery is discussed (for example, robotic versus open surgery), and also alternative options to surgery. The CCU MDT also enables discussion and exploration of curative versus palliative goals in the context of the patient’s wishes, expectations, and quality of life.

This patient-centred approach and shared decision-making are key factors in determining an objective risk assessment and risk prediction. The overall outcome of the CCU MDT process allows us to facilitate more informed decision-making and patient consent.

Patient outcomes
Of the 78 patients referred to the CCU MDT between 2016 and 2018, a decision to proceed with surgery was recommended in 58 cases. Eight of the 58 patients did not have surgery before the proposed date.

Outcomes for the 20 patients that the CCU MDT did not recommend for surgery are shown below. It is to be noted that three of the four patients who were declined surgery at RMH and who subsequently had surgery at another institution died within 90 days of surgery. The remaining patient left hospital after three months.

Financial impact
We involved the RMH’s costing team and a health economist to look at the financial impact of the CCU MDT. The cost of care for patients going through the CCU MDT and not proceeding with surgery (undergoing alternative non-surgical oncological care at RMH), was compared with the cost of matched patients having the same surgical procedure at RMH from a historical dataset plus the cost of the CCU MDT. The cost of the CCU MDT was estimated at 0.25 sessions of direct clinic care for five consultants and two hours of Band 7 health professionals’ time for 42 weeks per year (Table 1).

The overall estimation of cost is likely to underestimate the actual savings because matched patients were not objectively identified as high-risk in the calculation and had fewer complications, thus costing less. The inference from the calculation was that the CCU MDT’s decision was the cause of the patient not having surgery.

Conclusion
The development of the CCU MDT for high-risk surgical cancer patients is one of the first of its kind in the UK, and has allowed us to develop a robust perioperative decision-making process for those high-risk patients considered for cancer surgery. This process has been vital to ensure patients have the right surgery at the right time and in the right place, and is likely to have resulted in financial benefit.

Table 1: The financial impact of the high risk surgical patient CCU MDT

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survived</td>
<td>45</td>
<td>94%</td>
</tr>
<tr>
<td>Died within 30 days</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Died within 90 days</td>
<td>1</td>
<td>2%</td>
</tr>
</tbody>
</table>

Calculation of the proposed savings by the CCU High Risk Patient MDT for every patient going through the process and not having surgery (undergoing alternative non-surgical oncological care)

Median (IQR) savings to trust
£18,342
£7,342 – £25,490

Reference
Dundee RCoA Membership Engagement Focus Group: November 2018

The College is committed to improving the way we engage with you, our fellows and members. As part of this commitment, the Membership Engagement team invited all fellows and members to join us in Dundee in November 2018 for a Membership Engagement Focus Group. We had already facilitated a number of focus groups in London last year and internationally via Skype, and wanted to expand this opportunity for fellows and members who live in other areas of the UK.

Chairied by RCoA Council Member and Chair of the RCoA Scottish Board, Dr Sarah Ramsay, the focus group was a structured, yet open, space for attendees to share their views and concerns, as well as to let us know what they value and would like to see more of. This was a chance to shape the College’s priorities and improve our services. Together with the feedback we get from our all-membership survey, the qualitative information and insight we obtain from focus groups is invaluable in understanding and improving our services.

Dr M Al-Husein
Chairman of the Examination Committee of the Jordan Board in Anaesthesia

I have referred most of my residents to courses at the College to motivate them towards higher education and training. Regrettably, almost all doors are closed, as there are almost no openings for further training or even post-training fellowships.

It was a long journey from Amman to London, to Edinburgh, and finally to Dundee, where I walked into lively discussions.

Throughout the discussions between all groups, two main ideas came to the forefront: all individuals within all groups were there solely for the best interest of the College, and the anticipation that the College is losing valuable opportunities for progression.

Throughout my journey to Dundee I continuously questioned the purpose of my trip and my role in the meetings and at the College. Ultimately, I have come to see that just like all participants of the focus groups, I too want to continue the legacy of the College in shaping and guiding others like myself to improve and, in turn, help improve others.

The meeting was important in allowing the College to participate in the vision that the members and fellows have for its future and its growth.

It is essential that similar meetings continue to occur, allowing members and fellows to bestow valuable thought and advice. The College must continue to build on this relationship with its members. The Council members do not necessarily accurately represent the views of all members at all times.

I think the College needs to, and is now willing to, open avenues for doctors from outside the UK to refine their education and training. The benefit here has proven to be twofold – not only do the doctors gain prestige and expertise, but also the College itself shifts into the international community and becomes part of a larger institutional movement, one that is respected worldwide.

Dr Kate Arrow
ST6 Anaesthesia, Tayside School of Anaesthesia, Scotland

As a higher trainee I felt it important to raise the issue of engaging post-FRCA Anaesthetists in training. Ideas included practical support for consultant interviews, involvement in RCoA projects to give trainee-clinical perspective, exam observation, and opportunities for RCoA-endorsed improvement work.

While we discussed the issue of London-centricity, the arrival of a Member all the way from Jordan soon made our London travels seem relatively trivial.

The mix of grades, geographical base, subspecialties and different career stages made for an interesting discussion, and important issues raised included support in revalidation, interaction with international members, and locations and content of meetings and training.

It was a fantastic opportunity to gain insight into the issues affecting consultants and to voice ideas for trainee engagement.

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Enhancing perioperative care: a novel model

The initiation in 2015 of the RCoA’s drive for perioperative care services has led to new pathways to ensure optimal perioperative care. We recognised that patients who have complex medical problems were finding themselves being looked after by a multitude of different members of the surgical team and ‘single-organ specialists’, leading to a lack of holistic care and support.

We would like to share our experience with our novel model of the dedicated ‘perioperative anaesthetist’ at Sandwell and West Birmingham Hospitals, which has led to considerable and demonstrable improvement in care and outcomes.

The ‘perioperative anaesthetist for the week’ does a morning session (primarily based in the ward) on all five days of the week, who is primarily based on the ward, provides perioperative care in partnership with the orthopaedicians and the wider surgical team. This involves pre-operatively planning and scheduling for all seven days in a week.

Figure 1 Improvement in anaesthesia indices since the standardisation of care for hip-fracture patients

We have an ongoing data-collection process which provides continuous feedback on our perioperative process and outcomes, enabling us to identify areas for quality improvement. Our locally collected data demonstrates improvements in outcomes such as reduced postoperative complications, improved pain scores, reduced cancellation rates, and reduced rates of serious untoward incidents in hip-fracture patients.

We hope that with the simple process of standardisation of care we can continue to significantly improve outcomes, and ultimately to improve quality of care for surgical patients throughout their perioperative experience.

References:
1 Falls and Fragility Fracture Audit Programme (FFFAP): National Hip Fracture Database (NHFD) report for our trust (last accessed 15/10/2018).
Simulation and multiprofessional crisis resource management (CRM) team training

The College promotes multiprofessional team training through the Guidelines for Provision of Anaesthetic Services (GPAS) and Anaesthesia Clinical Services Accreditation (ACSA). NHS England also emphasises team training and educating staff in Human Factors within its National Safety Standards for Invasive Procedures [NatSSIPs] framework (2015). However, we know little about the quality, quantity or outcomes of team training that is undertaken within different hospital settings.

Hence, following publication of the RCoA Simulation Strategy [see RCoA Bulletin, March 2019], the Clinical Quality Directorate has prioritised a work programme to pilot and establish a national quality-assured approach to multiprofessional CRM team training relevant to anaesthetic practice and perioperative care. This will focus on regular in-situ rehearsal of team-based skills and drills for infrequent, difficult or critical situations.

1. Enhanced team briefing – a daily mental and verbal five-minute rehearsal for teams to talk/walk through their response to relevant critical situations, prompted by prespecified reference action cards that also signpost relevant evidence-based team skills and behaviours.

2. Rapid system stress tests – monthly coordinated 15–20-minute in-situ team exercises with peer-led observation and micro-debriefing, designed to provide assurance on the readiness of local systems and team responsiveness to specific critical situations.

3. Full immersion safety-system tests – in depth, planned testing of existing or new systems, processes, environments, care pathways and interactions with other teams to demonstrate safety-critical system responsiveness – conducted 6–12 monthly according to team and service needs.

Evidence of implementation might include individual logs [reviewable at appraisal] and a department/trust systems safety audit. Peer review of safety-systems testing would enable dissemination of good practice and demonstrate responsiveness to national safety alerts or changes in standards of practice.

If you are interested in helping to design, pilot and evaluate these interventions, please email: funderson@rcoa.org.uk.

Long-term impact of crystalloid versus colloid solutions on renal function and disability-free survival after major abdominal surgery

This paper represents analysis of one-year follow-up data from a previous Belgian, double-blinded trial comparing goal-directed fluid therapy using crystalloid [Plasmalyte] and colloid [hydroxyethyl starch]. The safety of colloid therapy is controversial, with some intensive care studies suggesting nephrotoxicity, although such studies have shown no ill effect.

Patients undergoing major abdominal surgery received maintenance crystalloid therapy, along with either colloid or crystalloid boluses delivered in a goal-directed manner by a closed-loop automated system. Follow-up of the 160 patients showed no difference in renal function at one year, with lower disability scores and higher disability-free survival in the colloid group. This is likely to relate to lower rates of 30-day postoperative complications seen in the colloid group in the original publication.


What is the effect of perioperative intravenous iron therapy in patients undergoing non-elective surgery? A systematic review with meta-analysis and trial sequential analysis

Perioperative anaemia pathways usually focus on elective procedures; this meta-analysis sought to assess the effect of intravenous iron preoperatively in anemic patients having emergency surgery.

Three randomised controlled trials (RCTs) with 605 patients were included in the meta-analysis. No effect on infection rates, time to resolution of anaemia, or transfusion requirement was shown. There was no difference in length of stay, 60-day mortality, or quality-of-life scores.

The authors suggest that further large RCTs are needed to detect a difference in transfusion requirement. These studies were underpowered for this outcome. Variability in dosing regimes and inclusion of only hip fracture and kidney transplant patients limits the generalisability of results.


Preoperative systemic inflammation and perioperative myocardial injury: prospective observational multicentre cohort study of patients undergoing non-cardiac surgery

Inflammatory response is a known contributor to myocardial injury, and Neutrophil lymphocyte ratio (NLR) is a readily available measure of inflammatory response. This prospective study aimed to elucidate any association between a pre-existing inflammatory response and perioperative myocardial injury. NLR and high-sensitivity troponin T (hsTnT) levels were measured in 1,652 patients over the age of 45 undergoing non-cardiac surgery on the first three postoperative days.

There were significant association between myocardial injury and raised NLR preoperatively (OR: 2.56 [95% CI: 1.62–4.07], P=0.0001). They therefore concluded that preoperative NLR is independently associated with perioperative myocardial injury, and that chronic systemic inflammation may contribute to the development of perioperative myocardial injury.


Relationship between preoperative anti-depressant and anti-anxiety medications and postoperative hospital length of stay

An ever growing proportion of patients are taking anti-depressant and anti-anxiety medications at the time of surgery, with potential impact on postoperative pain management, altered coping mechanisms, and medication-related issues. This retrospective analysis of administrative data aimed to examine the relationship between preoperative medication use and length of stay.

Data from more than 48,000 patients undergoing non-cardiac surgery between January 2011 and December 2014 was examined. Patients taking either anti-depressant or anti-anxiety medications had an increased length of stay compared to those who were not (incidence-rate ratio 1.04 [95% CI: 1.001] and 1.1 [95% CI: 1.04] respectively).

Although this study does not prove causal correlation, it suggests these patients may require greater holistic attention in both the pre- and postoperative periods.


Preoperative use of anti-depressants and anti-anxiety medications and postoperative hospital length of stay

Dr. Professor Bryn Baxendale, Chair, RCoA Simulation Working Group and Consultant Anaesthetist, Nottingham University Hospitals NHS Trust

Dr Marie Nixon RCoA Clinical Quality Advisor

The College is committed to developing a collaborative programme for the delivery of perioperative care across the UK: www.rcoa.ac.uk/perioperativemedicine
AS WE WERE...

Gardeners and herbalists: the first anaesthesiologists?

Most anaesthesia historians define the beginning of modern anaesthesia as the moment when William Morton gave ether anaesthesia in the Massachusetts General Hospital on 16 October 1846. But in fact, anaesthesia had been created many times for many hundreds of years before this. The problem lies in trying to produce absolute scientific proof for events hundreds or thousands of years ago.

Opium has been available for use for at least 6,000 years. Seeds of Papaver somniferum have been found in Neolithic burial sites in Spain. The Egyptian civilization created a wealth of medical papyri in which obscure recipes defy modern pharmacological rationalisation. However, they did use Blue Lotus flowers which, when steeped in wine for some time, created a sedative effect from the alkaloids, like nuciferan.

Mandrake root was a popular ingredient in sedative recipes from the time of the Greeks right through the Middle Ages. Dioscorides described the use of mandrake to produce an unconscious state. The effect from the alkaloids, like nuciferan, was the same, and then secondly the proximity of therapeutic and toxic threshold. In one of the Cambridge University Libraries there is an illuminated manuscript entitled ‘How to make a drink that men call dwale to make a man sleep whilst men cut him’. This drink contains six plant extracts: datura, atropine and scopolamine.

Opium contains curcumin and was popular in Ayurvedic medicine as an analgesic and clove (which contains eugenol and were used for the relief of toothache). Willow trees contain salicylates, and their products were used by the Sumerian and Assyrian civilizations. Aspirin was derived from meadowsweet by Bayer following an idea put forward by Felix Hoffman. Lettuce was regarded as a useful sedative, and Beatrix Potter, who herself had a huge herbal garden at her house in Ambleside and actively collected plants for medicinal use during World War One, highlighted this in The tale of the Flopsy Bunnies who ate too much of Mr McGregor’s produce and were captured by him while sleeping off the effects!

Socrates had experimented with a herbal drink called ‘professin’ – literally cannabis boil powder’. This, he had apparently used to create an anaesthetic state, but the exact constituents remain unclear as all his writings are thought to have been destroyed after his execution in 399 BC. This contained two forms of arisaema. After intensive research he created a mixture which had a standard effect, and on 13 October 1804 he produced anaesthesia for the removal of a breast carcinoma. This was the first confirmed anaesthetic in modern times. Hanoaka went on to teach his method to numerous other surgeons in Japan, and this was the accepted form of anaesthesia until information about ether and chloroform reached Japan.

Seishu Hanoaka – picture courtesy of Professor Akitomo Matsuki, Hakodate, Japan

Manuscripts across Europe and the work done in Japan indicate that forms of herbal anaesthesia were regularly created for many centuries prior to the ‘accepted dates’ for the introduction of our specialty. It is likely that more and more information will come to light on these matters as the translation and digitisation of manuscripts and books from Arabic, Indian and Chinese sources continue.

References
1 Syndics of Cambridge University Library (MS Dd.6.29: Ff14r-v).
2 Matsuki A, Seishu Hanoaka and his medicine. Hirosaki University Press, 2011.
LETTERS TO THE EDITOR

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

Dear Editor,

Letters page, RCoA Bulletin: a pedant writes, and gets it wrong

(RCoA Bulletin, 113:56-57)

Dr Smith, in the last issue, describes herself as a ‘pedant’, in having a low tolerance for poor medical English, and particularly for badly-spelled medical terms. Unfortunately, in particular she has misspelled the word melena as melaena [sic]. Schadenfreudelicious!

I too used to struggle with this one, until I noticed that the ‘mel’ in melena shares the same root as the ‘mel’ in melanin – from the Greek for ‘black’, so or google just told me.

I expect there will be correspondence in your next issue correcting some error in this letter.

Yours in anticipation,

John Glen
Consultant in ICM, North Wales

I thank Dr Glen profusely for correcting my egregious misspelling. The error had gone unnoticed not only by me, but also several fellow pedants, including the Editor himself. A reminder of the etymology is most welcome. I shall be found hanging my head in shame (and buying him! A reminder of the etymology is most welcome.

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Correcting some error in this letter.

William FS Sellers
Locum Anaesthetist

Dr Emma-Jane Smith
ST5 Anaesthetics & Intensive Care Medicine, Lewisham and Greenwich NHS Trust

Dr David Bogad

As We Were: ‘Chair dental GAs’: the last blood sport in anaesthesia, or the last art form in anaesthesiology?

(RCoA Bulletin, 113:56-57)

Inhaling 100% N2O is still possible

The operator could deliver 100% nitrous oxide to the patient with the Walton five dental anaesthetic machine pictured in Dr Adrian Padfield’s ‘Chair Dental GAs’ article (Bulletin 113:56-57), as could the contemporary McKeasant (Figures 1 and 2). Non-dental anaesthetic machines could deliver 100% well into the early 2000s, when a child with seizures was mistakenly given N2O instead of oxygen in an Accident and Emergency department and died. This expedited new machines with linked oxygen/ N2O flowmeters delivering a maximum 75% N2O. The illegal recreational use of 100% N2O continues. The contents of an 8 gram N2O whipped cream maker cartridge is released into a balloon (a circuit un-alphabeticised by Professor Mapleson), inhaled with rebreathing and a breath-hold. To measure the amount of gas produced, a manufactured-for-purpose aluminium ‘cracker’ pierced a N2O cartridge (Figure 3) to release gas inside a sealed anaesthetic reservoir bag. By counting the number of times a 60ml syringe was filled and evacuated when emptying the bag, a volume of 3.67 litres N2O was measured.

William FS Sellers
Locum Anaesthetist

Lothian

As We Were: ‘Chair dental GAs’: the last blood sport in anaesthesia, or the last art form in anaesthesiology?

(RCoA Bulletin, 113:56-57)

Dr Adrian Padfield asks whether the final ending of the administration of general anaesthesia in dental surgeries in 2001 was one hundred years too late. If so, it was not for want of trying by anaesthetists. In the extract below, taken from an article in the Lancet in 1911, Dr Frederic Hewitt mentions his failure to persuade the British Dental Association to support the restriction of anaesthetic administration to doctors.

In May, 1909, Sir Donald MacAlister, in his presidential address to the General Medical Council, drew special attention to the subject of anaesthetics, and reported that practically all the examining bodies for medical qualifications had now given effect to the recommendations of the Council in regard to instruction in anaesthetics. In the same month a committee was appointed by the Council ‘to consider the proposals for legislation on the subject of anaesthetics which have been or may hereafter be put forward.’

Whilst the question was thus receiving adequate consideration at the hands of the dominant educational authority it began seriously to attract the attention of the British Dental Association. At the annual meeting of this association at Birmingham the present writer (ad hoc) put forward the proposal that anaesthetics be restricted to the hands of a small number of people. The resolution was, in fact, passed almost unanimously protecting against any legislation which would make it illegal for registered dentists to administer anaesthetics for dental operations. It was contended that any such legislation would not be ‘in the best interests of the public.’

Reference


David Hatch
Emeritus Professor of Anaesthesia, 1999 Hewitt Lecturer. RCoA

As We Were: ‘Chair dental GAs’: the last blood sport in anaesthesia, or the last art form in anaesthesiology?

(RCoA Bulletin, 113:56-57)

Articles on the history of anaesthesia are always to be warmly welcomed. Consequently I read with great interest and pleasure Dr Adrian Padfield’s eloquent essay on ‘Chair Dental’ GAs, a subject on which he is an authority. Nevertheless I feel compelled to remove the rose tinted spectacles of nostalgia just for a moment.

In 1959 no less a figure than Victor Goldman while at Eastman Dental Hospital espoused his 4th breath technique as follows. The patient inhales 100% nitrous oxide until asleep and deeply cyanotic, and then air is given every 4th breath for 2 to 3 minutes. To avoid the damaging effects of cerebral hypoxia it is recommended, in Dr Goldman’s words, that oxygen be judiciously added for longer procedures or if there is an increase in respiratory rate indicating marked hypoxaemia. One assumes this was a popular method through the 1960’s and beyond. It was not until 1973 that the Synopsis of Anaesthesia, by then in its 7th Edition, began to advise caution against the use of a technique which by then had earned nitrous oxide the chilling sobriquet of the Black Gas.

In skilled hands that no long term harm was done to children’s developing brains as teeth were whipped out in record time is not doubted. But what of the single handed dentist administering their own anaesthetic? A uniquely British eccentricity, chair dental anaesthesia was never exported, as Dr Padfield points out, and perhaps that is just as well.

Yours sincerely

Matthew Down
Consultant Anaesthetist, Sunderland Royal Hospital

Reference

Dear Editor,

Anaesthetic Soapbox #1 “No, I don’t want 2 ml of b***y fentanyl!”

(RCoA Bulletin;113:40–41)

I applaud Dr Harrop-Griffiths’ endeavours to encourage critical and reflective thinking of our practices, yet I feel the piece has a muddled overall message. I feel the trainee at the end of the session may be somewhat confused when some of their answers to justify their use of fentanyl as part of induction are restated then reformatted as ‘caveats.’

The wording of ‘purposeless ritual’ strikes me the most. ‘Ritualisation’ in medical practice is acknowledged in phenomenological medical philosophy.

A ritual ‘orientates’ a person to what is important to them (a form of value-based medicine); a ritual gives an ‘order’ of things to follow, as if numbered. Such ordering is most useful when events can be uncertain, dangerous or stressful. Rituals promote solidarity, usually by bringing a ‘team’ together, creating a certain ‘power’. Take the example of resuscitation – the ‘team’ works in an ‘order’ in a seemingly uncertain and stressful situation to ‘orientate’ towards a desired outcome.

The fact that fentanyl is commonly used at induction is, I believe, owed toward it fulfilling a part of a ‘purposeful ritual’ when used correctly during induction, that is reproducible and likely to reinforce the ‘pharmacological tic’ described. This is why it becomes a ritual. The shared experiences of ODAs, trainees, trainers, and patients makes it endure as part of our culture and rites. But, like rituals, when meaning is lost ‘purposeless’ ensues. Fentanyl’s incorrect use undermines the ritual as a whole. I’d encourage our colleagues to reflect on this point which is what I believe Dr Harrop-Griffiths was attempting to convey.

Yours faithfully,

Dr Ahmed Gilani
ST6 Anaesthetics, Birmingham

Reference


Dear sir

I am grateful to Dr Gilani for his interest in my Soapbox article; I agree with much of what he says about rituals in medicine. I teach the trainees who are unfortunate enough to find themselves in theatre with me that there are three reasons to do things during an anaesthetic and that they all start with the letter ‘R’.

■ if it is Recommended in guidance from a body competent to provide such guidance

■ if it is Rational and is based on both logic and a knowledge of the relevant physiology, pharmacology, anatomy, etc

■ if it is a Ritual

The important aspect of the last of the three is that (a) we must be aware that what we are doing is a ritual and (b) the ritual should not have the capacity to harm the patient in any way. If you dance around before taking a rugby place-kick like Jonny Wilkinson or you touch the side of an aeroplane before getting onto it, you are knowingly performing a ritual that may have some value to you but poses no substantive threat to either the rugby ball or the aeroplane. I suspect that many of those who give fentanyl immediately before induction are not aware that what they are doing is a ritual. If you really need to inject 2 ml of something as a ritual at the start of an anaesthetic, may I suggest saline?

Kind regards,

William Harrop-Griffiths

PS I estimate that about 75 per cent of obstetric anaesthetic practice is ritual of some sort, but that will be the subject of another in this series of Soapbox articles.

Dear Editor,

Letter to the Editor: Airway Training

(RCoA Bulletin;113:69)

Anthony Rubin is absolutely correct when it comes to airway training; the gum elastic bougie and blind nasal intubation are both (literally) life savers. I can reassure him that the technique of blind nasal intubation is far from dead, and is in regular use by this craniofacial anaesthetist; it has got me out of a tight spot on many occasions. Mind you, I was taught the technique by a master: Dr Rubin himself!

Bernard Norman
Consultant Anaesthetist

Dear Editor,

Anaesthetic Soapbox #1 “No, I don’t want 2 ml of b***y fentanyl!”

(RCoA Bulletin;113:40–41)

I would like to compliment Dr Harrop-Griffiths in his excellent and insightful provoking Soapbox article.

I noted an interesting error in the article’s accompanying image, however...

The cannula in the image, a safety version of the BD Venflon is being used with the sharp styllet needle still in it. Not only does this bypass the sharps safety system for which it is designed, but I expect whatever is injected via the port will leak from the open end (perhaps just as well if it is fentanyl...)

I am sure this is not a technique that Dr Harrop-Griffiths would recommend to his trainees.

Will the next Anaesthetic Soapbox article be accompanied by an image demonstrating a cannula being used in the correct way, as well as avoiding the back of the hand?

Maybe I too am getting overly pedantic as I progress through the years!

Yours faithfully,

Dr James French
Consultant Anaesthetist and Anaesthetic Equipment Lead, Nottingham

Dr French was not the only eagle-eyed reader to spot this. Enquiries reveal that this photo comes from a series hosted by someone who we have decided to refer to as ‘a highly respected senior consultant’, who is holding the pinprick syringe. The good news is that no patient was harmed in the process, as the ‘cannulated’ hand (actually the hand onto which the cut cannula has been taped) is that of the photographer. This still doesn’t explain the apparent presence of the needle inside the cannula which, despite the editor’s Pavor-like doggedness, remains a mystery.

Dr David Bogod
Editor

OBSTETRICS ON-CALL

Dr Reena Ellis
ST3 Anaesthetist, East Midlands

My Pain is Your Pain

Until the Shiny Point is dulled

easy by sodium blockade which softens the edges

soaring you onwards towards a scalpelp delivery

Tell me, what’s a Normal Delivery?

Each unique but each alone

You journey on,

Every path takes you toward

the rainbow’s end.

Chytricin Driven

You suddenly arrive

pain forgotten and dismissed.

But not for us.

For our role lies at the end of a syringe.

We create a new experience,

changing more than just one life,

but at what Cost?

How closely do we consider the impact

of how we impart our skills?

The endless pressures of screaming wear thin

in the deafening darkness at 3am.

Can you retain your ability

to empathise,

when you’ve reach this frayed end?

No time to consider

No time left to reflect

They’re calling again

rush and run

be quick and fast and good and kind

and be sure, to come back tomorrow

for some more

as when you find yourself

on the other side

you’ll be grateful

for the golden glide

of that Sodium Blockade.
Research, Education and Travel Grants

The National Institute of Academic Anaesthesia (NIAA) has several small grants funded by the Royal College of Anaesthetists for the purpose of supporting research, education or travel connected with the study of anaesthesia. Priority will be given to educational projects, the presentation of original work or the provision of education to developing countries.

Applications are invited for the following funds:

**Ernest Leach Research Fund**
This fund was established in June 2011 to be utilized for the purposes of research.

**Value up to £2,500**

**Sargent Fund**
For education and research purposes.

**Value up to £2,500**

**Belfast Fund**
To fund grants for educational purposes.

**Value up to £1,600**

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

You can read about previous successful projects by visiting the NIAA website here: www.niaa.org.uk/RCoA-Small-Grants for the purpose of research, education or travel connected with the study of anaesthesia.

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

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

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

You can read about previously successful Maurice P Hudson Prize applicants by visiting the NIAA website here: www.niaa.org.uk/RCoA-Maurice-P-Hudson-Prize-Winners

### To apply
If you are an anaesthetic or intensive care doctor in training and the principal author of an article as outlined above and published, or accepted for publication, since 1 August 2018, please submit your article along with a copy of your curriculum vitae and a covering letter by email to the NIAA Co-ordinator at the address below by 5.00pm on Friday 6 September 2019. A prize of £500 is available. Please note that only one article may be submitted per applicant.

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

### CALL FOR PROPOSALS FOR SNAP3

**The Royal College of Anaesthetists** requests those wishing to suggest a topic for the 3rd Sprint National Anaesthesia Project of the Royal College of Anaesthetists to contact hsarc@rcoa.ac.uk

As a guide we suggest the topic should:

- be important to patients
- be important to anaesthetists
- be currently incompletely studied in incidence or nature
- be a short observational clinical research study
- recruit a large number of patients from as many NHS hospitals as possible in a short period of time
- engage ‘grass-roots’ anaesthetists, particularly trainees, in delivering the studies.

Topics that may potentially involve collaboration with other specialties and/or international collaboration in SNAP3 are encouraged, though this is not essential.

**Closing date:** 9.00am, Friday 31 May 2019

---

**To apply**

Please visit www.niaa.org.uk/RCoA-Small-Grants to view the assessment criteria and download a copy of the application form, which must be emailed to the NIAA Co-ordinator at the address below. The deadline for applications is 5.00pm on Friday 6 September 2019.

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

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

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

Applications for Macintosh Professorships are open to fellows and members of the Royal College of Anaesthetists and other clinicians and scientists involved in anaesthesia, critical care and pain management within the United Kingdom. Applications will be considered by the Board of the National Institute of Academic Anaesthesia and expert external advisers. Depending on the quality of applications, the review panel reserves the right to award a Professorship to more than one candidate in any given year.

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

You can read about previously awarded Macintosh Professorships by visiting the NIAA website here: www.niaa.org.uk/RCoA-Macintosh-Professorship

**To apply**

To apply, please submit a synopsis of your proposed lecture, along with your curriculum vitae and covering letter by email to the NIAA Co-ordinator at the address below by 5.00pm on Friday 6 September 2019.
On Wednesday 5 December, the NIAA Grants Committee met to consider the second round of applications for 2018 on behalf of the Association of Anaesthetists and Anaesthesia, the British Journal of Anaesthesia, the Royal College of Anaesthetists, and the College of Anaesthetists of Ireland.

The committee considered 32 applications over five categories for a requested sum of £1,599,632 and made a total of 12 awards over four categories to a value of £665,073. Success rate: 36 per cent.

A list of the successful applicants are in the following table and abstracts can be viewed online here: [link](https://niaa.org.uk/NIAA-Grant-Committee-Minutes#pt).

### Association of Anaesthetists/Anaesthesia Research Grants

<table>
<thead>
<tr>
<th>Name</th>
<th>Project Title</th>
<th>Funding (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Reema Ayyash</td>
<td>Investigating the associations between patient reported outcomes and preoperative frailty in patients with operable, potentially curative, colorectal cancer: an observational study</td>
<td>£40,000</td>
</tr>
<tr>
<td>Dr Sara-Catrin Cook</td>
<td>Improving outcomes for frail patients undergoing elective colorectal cancer surgery</td>
<td>£17,479</td>
</tr>
<tr>
<td>Dr Sara-Catrin Cook</td>
<td>The Videolaryngoscope Airway Database App Project</td>
<td>£4,882</td>
</tr>
<tr>
<td>Dr Louise Savic</td>
<td>Teicoplanin Anaphylaxis: Development of a diagnostic pathway, and elucidation of the underlying allergic mechanism</td>
<td>£20,000</td>
</tr>
<tr>
<td>BJARCoA Project Grants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Tristan Bekinschein</td>
<td>How are neural mechanisms underpinning touch-evoked pain modulated by sensory expectation and cognition in individuals with Complex Regional Pain Syndrome</td>
<td>£54,272</td>
</tr>
<tr>
<td>Prof Philip Hopkins</td>
<td>Transcriptional and functional changes underlying acute and chronic mitochondrial dysfunction in human and murine malignant hyperthermia</td>
<td>£25,663</td>
</tr>
<tr>
<td>Prof David Lambert</td>
<td>Use of novel fluorescent probes to examine MOP/NOP interaction studies with Celbranopadol and AT-121 as mixed agonists</td>
<td>£59,829</td>
</tr>
<tr>
<td>BJARCoA Non-CLinical PhD Studentships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Andrew Conway Morris</td>
<td>Mapping and manipulating the human neutrophil response to staphylococcus aureus</td>
<td>£99,342</td>
</tr>
<tr>
<td>Prof Helen Galley &amp; Dr Heather Wilson</td>
<td>Interactions between melatonin and endogenous opioid peptide release</td>
<td>£99,426</td>
</tr>
<tr>
<td>Dr San Henson</td>
<td>Characterisation of metabolic dysfunction and altered T cell migration in lymphopoeic perioperative individuals</td>
<td>£92,481</td>
</tr>
<tr>
<td>Dr Manu Shankar Hari</td>
<td>Studying immune trajectory to determine optimal timing for immunomodulation in sepsis patients: Scientific cohort study</td>
<td>£89,331</td>
</tr>
<tr>
<td>BJARCoA History PhD Studentship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Stephanie Snow</td>
<td>The History of the First 100 Years of the BJA</td>
<td>£72,368</td>
</tr>
</tbody>
</table>

### Courses for the Royal College of Anaesthetists Examinations

<table>
<thead>
<tr>
<th>Courses</th>
<th>Dates 2019/20</th>
<th>Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary SBA/ClQ</td>
<td>26 July – 1 August</td>
<td>October 2019</td>
</tr>
<tr>
<td>Primary OSCE Weekend</td>
<td>4 – 6 October</td>
<td>January 2020</td>
</tr>
<tr>
<td>Primary Viva Weekend</td>
<td>19 – 20 October</td>
<td>January 2020</td>
</tr>
<tr>
<td>Primary OSCE/Orals</td>
<td>25 October – 1 November</td>
<td>January 2020</td>
</tr>
<tr>
<td>Final Written ‘Booker’</td>
<td>11 – 15 August</td>
<td>February 2020</td>
</tr>
<tr>
<td>Final SBA/ClQ</td>
<td>19 – 22 August</td>
<td>February 2020</td>
</tr>
<tr>
<td>Final SAQ Weekend</td>
<td>23 – 25 August</td>
<td>TBC</td>
</tr>
<tr>
<td>Final Viva Revision</td>
<td>19 – 24 October</td>
<td>May 2020</td>
</tr>
<tr>
<td>Final Viva Weekend</td>
<td>22 – 24 November</td>
<td>June 2020</td>
</tr>
</tbody>
</table>

**Please Note:**

Trainees planning on attending MSA Courses must appreciate before they attend, that the MSA Courses are designed for Exam Preparation only, and include:

- Exposure to Exam Style Questions
- Opportunities to Practice
- Learn & Fine Tune Exam Techniques

The advice to Trainees is that they should only attend MSA Courses when they consider themselves adequately Prepared for the Imminent Examinations.

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

‘Like’ Mersey School of Anaesthesia on Facebook for News and Updates.
DEATHS
With regret, we record the death of those listed below.

Dr John Alexander, County Antrim
Dr Jack William Brooks, Colwyn Bay
Dr Thomas Victor Campkin, Southampton
Dr Keith William Dodd, Edinburgh
Dr Paul Andrew Holder, Aberdeen
Dr John Roland Lewis, Shropshire
Dr Narendar Kumar Mathur
Dr John Roylance, Birmingham
Dr Eileen Patricia Sapsford, Romsey
Dr Poornima Sreekumar, Newport
Professor John Andrew Thornton, Abergavenny
Dr John-Oliver Dunn University Hospital Southampton NHS Foundation Trust

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

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

Dr Suzanne Bell, Princess Alexandra Hospital, Harlow
Dr Jack William Brooks, Colwyn Bay
Dr Thomas Victor Campkin, Southampton
Dr Keith William Dodd, Edinburgh
Dr Paul Andrew Holder, Aberdeen
Dr John Roland Lewis, Shropshire
Dr Narendar Kumar Mathur
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NHS Improvement/NHS England
Implementing the NHS Long Term Plan – Proposals for possible change to legislation

Nursing & Midwifery Council
Standards of Proficiency for Midwives & Pre-Registration Midwifery Programmes

National Data Guardian
National Data Guardian for Health and Social Care: a consultation about priorities

British Orthopaedic Association
The care of the older or frail orthopaedic trauma patient

National Institute for Health and Care Excellence
CG190 Intrapartum care for healthy women and babies

Royal College of Obstetricians and Gynaecologists
Green-top Good Practice Paper no 16: Good Practice for Supporting the Family and Staff Following a Maternal Death

NEW TO THE COLLEGE
The following appointments/re-appointments were approved (re-appointments marked with an asterisk).

Deputy Regional Advisers

Anaesthesia
Northern
Dr I Whitehead as Deputy Regional Adviser for the Northern Region

Wessex
Dr M Jackson as Deputy Regional Adviser for Wessex in succession to Dr J Chambers

College Tutors

Wales
Dr M D L Williams [Prince Charles Hospital] in succession to Dr J Butler
Dr M Roberts (University Hospital of Wales) in succession to Dr J Hall

Northern Ireland
Dr G McClure (Ulster Hospital) in succession to Dr D T Lee

Scotland
South East Scotland
Dr O Daly (Royal Infirmary of Edinburgh) in succession to Dr S Thompson

West of Scotland
Dr V J Vallance (Haemyses Hospital) in succession to Dr J Duffy
"Dr S Smith [Royal Glasgow Infirmary]

England
East of England & Bart’s and the London
Dr M May (Basildon University Hospital) in succession to Dr V Shenoy

East of England
Dr S Grover (Lister Hospital) in succession to Dr M Simpson
Dr G Bastock (Ipswich Hospital) in succession to Dr H Bayce

East Midlands
"Dr A Kathigamanathan [Kings Mill Hospital]

London
South East
Dr H Thomas [Guy’s and St Thomas’] in succession to Dr M Scinski

Imperial
Dr E Caster Acting tutor at Charing Cross Hospital, covering for Dr N Shaxter

Oxford
Dr C Walker (Milton Keynes University Hospital) in succession to Dr M Simpson

North West
Dr M Anderson (University Hospital of Morecambe Bay NHS Trust) in succession to Dr C Caldwell

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Mersey
Dr C Gerard (Whiston Hospital) in succession to Dr J Slee
"Dr S Griffiths [The Walton Centre for Neurology and Neurosurgery]

South West
Peninsula
Dr N Campbell (Musgrove Park Hospital) in succession to Dr M Khakhar

Severn
Dr A Clarke [Bristol Royal Infirmary] in succession to Dr N Harvey

Yorkshire and the Humber
South Yorkshire
Dr R Brookle (Doncaster Hospital) in succession to Dr A Nair

Wessex
Dr S Radauceanu (Queen Alexandra Hospital) in succession to Dr M Jackson

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Dr Julia Bowditch, Salisbury NHS Foundation Trust
Dr Marika Chandler, Royal Devon and Exeter Hospital
Dr Helen Doherty, Freeman Hospital, Newcastle upon Tyne
Dr John-Oliver Dunn University Hospital Southampton NHS Foundation Trust
Dr Saumitra Ghati, Oxford University Hospitals NHS Trust
Dr Nadeem Mujtaba, University Hospital Southampton NHS Foundation Trust
Dr Jonathan Paige, University Hospital Coventry and Warwickshire
Dr Benjamin Plumb, Musgrove Park, Taunton
Dr Ilies Clazi, University Hospitals Birmingham NHS Foundation Trust

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Volunteers Urgently Needed
Ethiopia Anaesthesia Development Project

Consultant and senior anaesthesia trainees required for short term (2-4 week) teaching visits to support the anaesthesia training program at Addis Ababa University.

Travel and accommodation costs reimbursed.

For further details please email EthiopiaDP@gmail.com
Closing date June 7th 2019

Global Anaesthesia Fellow
Ethiopia Anaesthesia Development Project

2 Anaesthesia Global Health Fellow posts commencing August 2019 and February 2020 for 3-6 months (starting dates are negotiable)

Based in Addis Ababa, Ethiopia
Main duties involve providing educational and clinical support to an expanding physician-led anaesthesia training program

DDA approved for COPF

Contact EthiopiaDP@gmail.com for further details

Trainee Conference 2019
(formerly known as the GAT ASM)
3-5 July 2019
Telford International Centre

Keynotes Include:
• Dr Peter Homa, Chair, NHS Leadership Academy
• Dr Colin Melville, Director of Education and Standards, General Medical Council

Booking now open
www.gatasm.org

Association of Anaesthetists

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EVENTS CALENDAR

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

MAY

Introduction to Leadership and Management: The Essentials
2–3 May 2019
RCoA, London

Anaesthetists as Educators: Anaesthetists’ Non-Technical Skills (ANTS)
7 May 2019
RCoA, London

JUNE

Regional Anaesthesia Masterclass
4 June 2019
RCoA, London

Airway Management: Training the Trainer
6 June 2019
RCoA, London

UK Training in Emergency Airway Management (TEAM)
10–11 June 2019
Saltash Hospital

Anaesthetists as Educators: An Introduction
11 June 2019
RCoA, London

FPM Study Day: Musculoskeletal System Examination for Diagnosing Pain Problems
12 June 2019
RCoA, London

FICM Annual Meeting: End of Life Matters!
13 June 2019
RCoA, London

Upates in Anaesthesia, Critical Care and Pain Management
17–19 June 2019
Mercure Hotel, Bristol

UK Training in Emergency Airway Management (TEAM)
20–22 May 2019
etc. venues St Paul’s, London

ANAESTHESIA 2019
20–22 May 2019
etc venues St Paul’s, London

JULY

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12 June 2019
RCoA, London

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etc venues St Paul’s, London

ANAESTHESIA 2019
20–22 May 2019
etc venues St Paul’s, London

A Career in Anaesthesia
9 October 2019
RCoA, London

UPDATES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

17–19 JUNE 2019 | BRISTOL

View the full programme online now

SEPTEMBER

FPM Exam Tutorial
2 September 2019
RCoA London

Presentation of Diplomates
6 September 2019
Central Hall, London

Advanced Airway Workshop
24 September 2019
RCoA, London

Upates in Anaesthesia, Critical Care and Pain Management
24–26 September 2019
RCoA, London

Developing World Anaesthesia
30 September 2019
RCoA, London

October

Anaesthetists as Educators: An Introduction
1 October 2019
RCoA, London

Anaesthetists as Educators: Simulation Unplugged
2 October 2019
RCoA, London

Leadership and Management: Leading and Managing Change
7 October 2019
RCoA, London

Ultrasound Workshop
8 October 2019
RCoA, London

November

UK Training in Emergency Airway Management (TEAM)
7–8 November 2019
Royal Infirmary of Edinburgh

Anaesthetists as Educators: Teaching and Training in the Workplace
14–15 November 2019
RCoA, London

Anaesthetists as Educators: Anaesthetists’ Non-Technical Skills (ANTS)
22 November 2019
RCoA, London

December

Winter Symposium
10–11 December 2019
RCoA, London

January 2020

Primary FRCA Revision Course
14–17 January 2020
RCoA, London

GA Sagain (Giving Anaesthesia Safely Again)
15 January 2020
Bradford Royal Infirmary

Final FRCA Revision Course
20–24 January 2020
RCoA, London

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.
Our series of Anaesthetists as Educators events support clinical educators in delivering high quality training and education in the workplace. Participation in the courses provides supporting evidence towards the GMC approval process for trainers.

An Introduction
11 June 2019 | RCoA, London
Provides an overview of postgraduate medical education in anaesthesia. This highly interactive course is suitable for doctors with no previous training in teaching or medical education.

Teaching and Training in the Workplace
Intended for doctors with some experience of teaching and supervising trainees, this course looks at the education and assessment of trainee anaesthetists and raises awareness of some of the key concepts associated with education.

Anaesthetists’ Non-Technical Skills (ANTS)
7 May 2019 | RCoA, London
For those wishing to increase their understanding of how behavioural aspects of performance contribute to patient safety. Learn about the concepts and vocabulary used to formulate a personal strategy using the ANTS framework.

Simulation Unplugged
2 October 2019 | RCoA, London
For those developing their knowledge and skills in delivering educational simulation. This course is designed to debunk the myths and get back to the nuts and bolts of what you and your learners need.

Full programmes available online

Regional Anaesthesia Masterclass
4 June 2019 | RCoA, London
Join us as we explore the use of Regional Anaesthesia at our first RCoA masterclass. Study the pros and cons of safely using Regional Anaesthesia, by looking at the past, the present and the future, including an in depth look at the latest research. Watch live interactive demonstrations where you can learn top tips from the experts on blocks for shoulder and chest surgery.

Exam Revision Courses

Primary FRCA Revision Course
Offering a combination of learning methods, including lectures, small group tutorials and practice MCoC, SBA and SAGQ papers, these revision courses will inspire confidence and ensure trainees are well prepared for the Primary and Final FRCA written examinations. These intensive courses cover the topics candidates typically have most difficulty with.

Final FRCA Revision Course
1–5 July 2019 | RCoA, London

A career in anaesthesia
9 October 2019 | RCoA, London
Are you a medical student or foundation year doctor and considering a career in anaesthesia? The RCoA is holding a half-day information session for those who want to find out more about the specialty. This day will focus on the general aspects of a career in anaesthesia, providing an insight into the world of clinical anaesthesia, providing an insight into the future of anaesthesia and the skills required.

CPD study days
21 June 2019 | Doubletree by Hilton, Hull
Hear about best anaesthetic practice, maintain your competence and earn CPD points to aid revalidation at our CPD study days. Join us in Hull for discussion on a broad range of engaging topics including:
- processed EEG monitoring
- anaesthesia for patients with cardiac disease undergoing non-cardiac surgery
- enhanced maternal care
- the paediatric difficult airway – The Vortex approach
- psychology for patients at high risk of post-operative pain
- guidance on communication, consent and giving professional opinions
- dealing with difficult patients
- perioperative management of the bleeding patient

Airway Workshops
Airway Management: Training the Trainer
6 June 2019 | RCoA, London
Discover how to deliver effective airway courses and teaching for multidisciplinary teams, in a cost effective manner.

Airway Workshop
Learn core technical and non-technical airway skills including awake tracheal intubation and front of neck access. Appropriate for all grades.

UK Training in Emergency Airway Management (TEAM)
10–11 June 2019 | Solihull Hospital
20–21 June 2019 | Royal United Hospital, Bath
28–29 October 2019 | RCoA, London
7–8 November 2019 | Royal Infirmary of Edinburgh

A two day simulator-based course designed to teach the knowledge, skills and attitudes required to safely manage the airway in an emergency situation outside the operating theatre.

Advanced Airway Workshop
24 September 2019 | RCoA, London
An extension of our Airway Workshop series, in this workshop you will enhance and refine your existing specialised airway skills. Aimed at senior trainees, airway leads and anaesthetic consultants.

A Care in Anaesthesia

Regional Anaesthesia
Provides an overview of postgraduate medical education in anaesthesia. This highly interactive course is suitable for doctors with no previous training in teaching or medical education.

Teaching and Training in the Workplace
1 October 2019 | RCoA, London
Intended for doctors with some experience of teaching and supervising trainees, this course looks at the education and assessment of trainee anaesthetists and raises awareness of some of the key concepts associated with education.

Anaesthetists’ Non-Technical Skills (ANTS)
11 June 2019 | RCoA, London
For those developing their knowledge and skills in delivering educational simulation. This course is designed to debunk the myths and get back to the nuts and bolts of what you and your learners need.

Full programmes available online

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17–19 June 2019 | Mercure Holland House Hotel and Spa, Bristol

Stay ahead of the curve and join us for three days of new ideas in anaesthesia, critical care and pain management. Discover new developments on the horizon from today’s thought leaders and learn how best to combat the growing issues you will face in your anaesthetic practice.

Programmes include:

**Bristol**
- anaesthesia at extremes of body weight
- perioperative care and dementia
- how to start a QI project
- consent in anaesthesia
- decision making in airway management

**London**
- muscle wasting in the critically ill patient
- intubating the unstable cervical spine
- long term outcomes following ICU
- awake tracheal intubation guidelines
- ICU in the 21st century: current challenges in the UK.

BOOK YOUR PLACE NOW – OUR UPDATES EVENTS SELL OUT FAST

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Discounts available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.