Brexit: Implications for anaesthesia and healthcare

Second NELA Patient Report
A view from the high-level isolation unit
The role of the nurse within perioperative medicine
From the Editor

So much can happen in a few short weeks. Britain votes to leave the European Union, appoints a new Prime Minister, and the Royal College of Anaesthetists re-brands. I hope you enjoy the new look Bulletin: it is the culmination of many months of other folks’ hard work, and the Bulletin benefits by default. Purple is the new Blue.

As always, there is something for everyone in this edition of the Bulletin, from novel ways of supporting our trainees with peer coaching and mentoring in the West Country, to a primary exam network in Wessex. We have updates from the Faculty of Pain Medicine on professional standards, and from the Faculty of Intensive Care Medicine on e-learning opportunities and on the new FICM website. From the NIAA, there is news of a new strategy and a cluster of other reports, giving details of the Clinical Trials Network launch, Quality initiatives and the first Research Awards event. The HSRC presents the latest results from the National Emergency Laparotomy Audit (NELA); and there are accounts from individual anaesthetists of what it was like to be an Allied doctor in Belsen in 1945 where typhus was out of control, and an intensivist in London in 2015 when Ebola was out of control in west Africa and the first patients had made it back to the UK.

You can read the latest updates on perioperative medicine, including the introduction to Bulletin readers of our recently appointed perioperative medicine National Clinical Leads (Mike Swart and Chris Snowden), and a view from the US. Rob Thompson, Chair of the Lay Committee, tells it straight in his article entitled: “Well, what do you patients want?” and concludes that the College’s Perioperative Medicine programme... addresses so many of the issues raised in... studies of what patients want.” Those of you who are still concerned about how perioperative medicine will be delivered may be relieved to read the conclusions of Emma McCone, Lead Sister, Pre-Assessment Services, Newcastle, that: “...we mustn’t forget that the people who will actually make it work are without doubt the nurses. It can’t be done without them and collaborative working must begin now.”

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Royal College of Anaesthetists is grateful for the contribution to the production of the Bulletin by
The President’s View

Brexit: Implications for anaesthesia and healthcare

‘Fog in channel – Continent cut off’
The Times, October 1957

Liam Brennan
President

The vote to leave the European Union (EU) is perhaps the most momentous decision that the UK electorate has taken since the end of the Second World War and the creation of the NHS. At the time of writing (in July), following what promised to be a protracted and unprecedented situation of simultaneous leadership contests in two of the UK’s major political parties, Theresa May has been appointed as Britain’s Prime Minister. She faces a series of challenges at a critical time following the Brexit vote, and at this period of such uncertainty, I have decided to use my Bulletin article this month to reflect upon some of the potential implications of the referendum result for our specialty, the wider profession, and healthcare generally in the UK.

Workforce

The UK is currently heavily dependent on the invaluable contribution EU migrants make to staffing the NHS and social care sectors. 130,000 people from the EU work for the NHS or in social care, including 10% of doctors, 5% of nurses and 5% of the social care workforce. The recent RCoA members’ survey reveals that 6.5% of our members originate from the European Economic Area (EEA).1

As we have emphasised recently in the national media2 and in a joint statement with our associated Faculties and the AAGBI3, we could not deliver a safe and sustainable anaesthetic, pain medicine and intensive care service without the pivotal contribution of EEA colleagues. The House of Commons Public Accounts Committee estimate that the NHS is short of at least 50,000 staff, and the College’s recent workforce census4 estimates a current 7% shortfall in anaesthetic workforce provision. Unless we do something soon this number is set to grow. Quite simply, we are not training and recruiting enough health and social care personnel, including anaesthetists.

Any situation that causes uncertainty and fails to value the current or potential EEA migrant workforce risks exacerbating the current acute NHS staffing problems. Freedom of workforce movement, a cornerstone of EU membership, is clearly going to be a major issue that will need to be unravelled in the weeks and months to come, if and when Article 50, signalling the UK’s desire to leave the EU, is triggered.

In addition to freedom of movement, existing European legislation affecting the healthcare workforce is also going to be prominent in the debate surrounding the UK’s exit from the EU. The European Working Time Directive (EWTD) has been a controversial issue in healthcare, and for the medical profession in particular, for many years. On one hand EWTD has been welcomed for the protection it brings for doctors and their patients from working excessively long hours, whilst others express concerns...
that doctors in training are denied the opportunity to gain valuable clinical experience and to maintain continuity of patient care. Let’s hope that this issue is not used too much as a political football, and that the needs of patients and our profession are the overriding concerns in deciding the way forward on this issue in the post-Brexit era.

Financial pressures
The financial challenge for the NHS received considerable attention during the referendum campaign, with the now infamous claim that a vote for Brexit would release £350 million per week of additional healthcare funding. With doubts being expressed by independent commentators, this sound bite has already been downgraded, with some of the Conservative leadership candidates pledging £100 million per week and some not being drawn at all.

Post referendum, there has been the predicted volatility in the money markets and foreign exchange rates, with some economic experts predicting a ‘high disruption scenario’ of a 6% fall in GDP by 2020. Simon Stevens, the NHS England CEO, has said that the financial stability of the NHS depends on a flourishing and growing economy, and that any extra investment should go into social care. However, more concerning is overall public spending, including that for health and social care, which would inevitably come under pressure if the UK economy went into recession jeopardising the already challenging NHS funding situation.

Clinical pressures
The clinical pressures on the NHS are huge, and much has been made of the potential additional burden that growing immigration to the UK brings to a system under considerable strain. Whilst a revised approach to immigration controls may arguably ease some of these pressures, what has not been so prominent in the debate are the healthcare requirements of the UK diaspora currently dispersed across the EU.

There are approximately 2 million UK citizens currently living, working and travelling in the EU, with 380,000 living in Spain alone. Currently, EU membership entitles our citizens to access to the host country’s public healthcare system on the same basis as the indigenous population. Post Brexit, it remains to be seen what the impact on the NHS would be of large numbers of ex-pats returning to the UK to access healthcare, particularly as many will be older people with more complex needs.

Medical and scientific research
The prospect of Brexit is causing considerable anxiety amongst the medical and wider scientific research communities for several reasons. With 23% of research scientists and 5% of undergraduates in our universities from the EU, constraints on freedom of movement would potentially limit the opportunities to travel, collaborate and share ideas. Financially, the UK receives 16% of all its research funding from the EU – £8 billion between 2006-2015. Projects funded by the EU or those planned under the umbrella of EU regulation may be jeopardised. Finally the European Medicines Agency (EMA), which is at the heart of pharmaceutical research and innovation, is currently based in London and employs over 800 people. The UK is the leading player in European pharma development, with 15% of the EMA budget invested in UK-led projects. Leaving the EU risks downgrading the UK’s pre-eminent position as, although the UK may still be able to access funding, it would not have the same influence on research policy that it currently enjoys. It also remains to be seen if a post-Brexit UK would sign up to the EU Clinical Trials regulations which are due to come into force in 2017-18. These are important, as they will harmonise procedures for the conduct of multi-centre clinical trials across the EU, ensuring consistency and transparency in reporting research outcomes.

Public health matters
There are over 80,000 pages of EU regulations related to public health related matters. These range from use of tobacco products to food regulation, from water and air quality to coordinated responses to pandemics. With legislative time in Westminster at a premium, if and when Article 50 is enacted, it will be a considerable challenge to ensure that such a vast number of EU regulations are scrutinised to decide which should and which should not be adopted into UK law.

Final thoughts
The vote to leave the EU has resulted in an uncertain future for the whole UK, with considerable challenges and unanswered questions for all of us who work in healthcare. The College reiterates its gratitude to and its support for all its members and the wider NHS workforce who contribute so much to healthcare in the UK. As we said in our statement in the aftermath of the referendum result, “we want to stress how much we value the contribution of every anaesthetist, pain medicine specialist and intensivist, whether from the UK or from the 30% of our membership from the EU and around the world.”

In the months ahead, Council and I will do all that we can to represent the needs of patients and the views of anaesthetists and our research colleagues in the post-referendum debate. As always, please let me know your views and, in particular, the impact the referendum result has had in your workplace.

References
1 RCoA members’ survey 2016.
2 Non-UK staff - Letter to The Times, July 1st 2016. (www.rcoa.ac.uk/node/23576).
3 Joint RCoA/FICM/FPM/AAGBI EU referendum statement, June 28 2016 (www.rcoa.ac.uk/node/23356).
4 RCoA workforce census 2015 (www.rcoa.ac.uk/census2015).
Guest Editorial

Controversies in preoperative carbohydrate loading

William Fawcett
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Consultant in Anaesthesia, Bury St Edmunds

The optimisation of a patient’s physical status prior to major elective surgery to prepare them to withstand the subsequent physiological changes is at the heart of perioperative medicine. Many of these areas have been common in preoperative anaesthetic practice for many years, for example optimal management of hypertension, heart failure, asthma, diabetes mellitus, etc. More recently, the concept of prehabilitation has been popularised, to boost functional physiological reserve to prepare patients for the inevitable decline that occurs in the postoperative period. Preoperative carbohydrate loading is now an integral component of the strategies used to attenuate the metabolic stress response of surgery.

The metabolic changes that occur as a result of surgery have been well characterised, and there is now greater understanding of the relevance of these changes and how they can be manipulated. The characteristic ‘stress’ response, in which neuroendocrine activation (pituitary and sympathetic nervous system) leads to a predictable series of metabolic changes, including catabolism and hyperglycaemia. In addition, there is an inflammatory response (e.g. interleukin release). The neuroendocrine activation can be quantified in several ways such as raised serum glucose, cortisol, growth hormone, catecholamines, etc; but at the very heart of these changes is insulin resistance, which increases with the magnitude of surgery.

Why should we be concerned about insulin resistance in the immediate postoperative period? It has a number of adverse effects, not only hyperglycaemia (from reduced serum glucose clearance and increased hepatic gluconeogenesis) with its attendant complications, but in addition reduced glucose uptake into muscle with poor muscle glycogen storage followed by muscle catabolism. Optimisation of muscle function is a key area for postoperative recovery, with numerous recent studies demonstrating that poor muscle function is predictive for postoperative complications. This has sparked interest in several areas such as prehabilitation. In addition, given the importance of muscle function and delaying fatigue for endurance athletes, there is a parallel between preparation for competitive sport and major surgery. One such parallel is carbohydrate loading which has been shown for about 50 years to improve muscle function and muscle glycogen. Some of the benefits of oral carbohydrates loading (along with associated fluid) are self-evident. The historical scenario of a patient arriving in a theatre-suite for major surgery after prolonged starvation and rendered dehydrated, insulin resistant and catabolic even before the first incision, has given way to patients now arriving in a relatively metabolically fed and euvolaemic state, with resultant improvements in patient comfort and wellbeing. In addition, a number of studies over the last 30 years have shown that carbohydrate loading (initially intravenous) reduced many of the undesirable effects of starvation and surgery. The benefits include less insulin resistance and hyperglycaemia, with the preservation of muscle function and muscle mass, reduced nitrogen loss, and an improvement in overall insulin sensitivity. At a
cellular level, carbohydrate loading improves intracellular signalling and anabolic pathways in muscle.\textsuperscript{10} There is also a reduction in length of stay with carbohydrate-loaded patients.\textsuperscript{15,16}

So, what are the concerns?

Is there an increased risk of pulmonary aspiration?
Carbohydrate loading consists of mainly maltodextrin (a polysaccharide), which is emptied from the stomach reliably after two hours. The most popular regimen is the administration of 800 mls on the night prior to surgery and 400 mls two to three hours prior to surgery. Fears of incomplete gastric emptying appear groundless. Various methods of assessing gastric emptying using scintigraphy, paracetamol co-administration (i.e. measuring the rate of rise in the paracetamol absorbed from the small intestine) and assessment of gastric antral cross-sectional area using ultrasound have all confirmed that gastric emptying still reliably occurs.\textsuperscript{17-19} Thus the risk of pulmonary aspiration of gastric contents should be low. The outcomes for an estimated 5 million patients who have received the carbohydrate loading within Enhanced Recovery Programmes would support this. Clearly, those patients with delayed gastric emptying (for example those with major gastrointestinal emergency or mechanical gastric outlet obstruction) are not suitable.

What is the optimal composition of the carbohydrate preload?
Currently most sachets, when diluted to 400 mls, will result in a drink of approximately 12.5\% carbohydrate with 135 mOsm kg\textsuperscript{-1}, and approximately 200 calories. Is this the best formula or would another carbohydrate composition be superior? This is addressed in more detail below.

Are the benefits of preoperative carbohydrate restricted to major elective surgery?
A trial is underway to evaluate whether patients who have suffered a hip fracture would benefit from preoperative carbohydrate loading.\textsuperscript{20} Perhaps, carbohydrate loading may be beneficial to medical patients too.

Is it safe to administer the preoperative carbohydrate load to the surgical patient with diabetes?
In 2008, Gustaffson and colleagues published a study titled “Pre-operative carbohydrate loading may be used in type 2 diabetes patients”, which has been cited nearly 60 times to promote carbohydrate loading for the surgical patient with diabetes.\textsuperscript{21} Close inspection of the methodology of the study reveals that the message of the title may be an oversimplification. The study was performed on only 25 patients with type 2 diabetes mellitus (T2DM), all with excellent glycaemic control and no evidence of either obesity or autonomic neuropathy. The control group consisted of ten healthy subjects. All the subjects had their usual medication the night before the study, and were then starved, receiving an oral carbohydrate-rich drink with 1.5g of paracetamol at 8.00am, and then the administration of all their normal medication. The results showed that glucose concentrations were back to baseline within 180 minutes for the subjects with diabetes and 120 minutes for the healthy controls. Gastric emptying time (estimated by measuring serum paracetamol levels) was not prolonged in the subjects with diabetes. The authors did acknowledge that peak glucose level was higher in the diabetic subjects than in the non-diabetic controls (13.4 ± 0.5 vs 7.6 ± 0.5 mmol litre\textsuperscript{-1}; P<0.01). On the basis of these findings, the authors concluded that preoperative carbohydrate loading may be used in the surgical patient with T2DM, as it caused neither prolonged hyperglycaemia or delayed gastric emptying. The findings and conclusions are to be expected. All the subjects of the study had superbly well controlled diabetes, had had all their normal medication, had no pre-existing autonomic neuropathy, and had had no surgery! However, since the majority of patients with T2DM do not have perfect glycaemic control and are obese, the results of this study are not representative. In addition, it does need to be emphasised that the diabetic patients did develop hyperglycaemia, and were not even subjected to the stress of surgery.
Is perioperative hyperglycaemia innocuous?
For many years, the primary aim of perioperative glycaemic control in the surgical patient with diabetes has been to prevent the catastrophic effects of neuroglycoaemia and diabetic ketoacidosis. However, various studies have now demonstrated that perioperative hyperglycaemia in the surgical patient with diabetes is associated with significantly increased mortality and morbidity. Thus, it is now accepted that hyperglycaemia in the surgical patient with diabetes needs to be prevented. This association between hyperglycaemia in the surgical patient with diabetes and increased risk of complications and death has been widely demonstrated, and has been discussed in recent reviews.22,23 However, it is now beginning to be appreciated that it is the patient who either has undiagnosed diabetes or who develops stress hyperglycaemia that is at the highest risk of harm from perioperative hyperglycaemia. In a retrospective study by Frisch et al, published in 2010, the case notes of over 3,000 surgical patients were reviewed, and the authors demonstrated that hyperglycaemia was associated with a worse outcome, and that patients with pre-existing diabetes fared better than those without pre-existing diabetes.24 These findings were repeated in the retrospective study by Kwon et al, which was published in 2013. In this study, the case notes of over 11,000 surgical patients were reviewed.25 The authors concluded that patients who had hyperglycaemia, as defined by a capillary blood glucose (CBG) level of >180mg dl⁻¹ (10mmol litre⁻¹), had a significantly increased risk of infection, re-operative interventions, and death. More importantly, those with hyperglycaemia on the day of surgery who received insulin had no significant increased risk of infections, re-operative interventions, or death. More recently, in a study published in 2015, Kotagal et al have replicated the findings that hyperglycaemia in patients not known to have diabetes, is a greater risk factor for harm than hyperglycaemia in patients known to have diabetes.26 They retrospectively examined the case notes of over 40,000 patients undergoing surgery in the state of Washington during the period from 2010 to 2012. In their study, 19% of the patients had pre-existing diabetes! But, more relevantly, they discovered that in the surgical patient without known diabetes there is a dose-response relationship between the level of CBG and composite adverse events. Furthermore, the non-diabetic patient who developed hyperglycaemia was less likely to receive insulin.

Thus, it can be concluded that hyperglycaemia needs to be prevented in all surgical patients. Moreover, it needs to be recognised that apart from patients with pre-existing diabetes, there are three further populations who are at risk of perioperative hyperglycaemia: patients with undiagnosed diabetes, patients with pre-diabetes/borderline diabetes, and thirdly those patients who exhibit stress hyperglycaemia. The incidence of undiagnosed diabetes/pre-diabetes is by definition unknown, but some studies suggest that it may be as high as 35% in some populations.27

Can preoperative carbohydrate loading cause hyperglycaemia?
Whilst it is appreciated that the aim of carbohydrate loading is to attenuate insulin resistance in the surgical patient, the effects of carbohydrate loading in surgical patients susceptible to hyperglycaemia appears at the very least to cause transient hyperglycaemia. As the incidence of diabetes and undiagnosed T2DM is increasing, and the United Kingdom is now teetering on the edge of a pandemic of diabetes, we argue that preoperative carbohydrate loading can no longer routinely be recommended without the regular monitoring of CBGs and treatment with insulin for any resultant hyperglycaemia. The use of carbohydrate loading is probably safe and efficacious in the surgical patient with diabetes, provided that the CBG will be regularly monitored and insulin is titrated to ensure that the CBG remains <10mmol litre⁻¹.

What are the recent developments in the constituents of the carbohydrate drink?
Newer preparations of complex carbohydrate drinks are now being commercially produced with the explicit aim of reducing the glycaemic surge associated with the traditional carbohydrate drink. The manufacturers of one such drink, Glycaemic Endothelial Drink (GED), claim that their product is superior as it contains less maltodextrin, and this reduced dose provides the benefit without the harm of excessive carbohydrate loading.28 Furthermore, GED contains citrulline, the pharmacologically active precursor of arginine, which is claimed to reduce gluconeogenesis and maintain a normal ratio of systemic arginine to asymmetric dimethylarginine (ADMA). There is evidence to suggest that an abnormal systemic arginine to ADMA ratio is associated with poorer patient outcomes. Before the widespread adoption of this novel type of carbohydrate drink, further studies are warranted to assess the safety and efficacy of these drinks, especially considering the potential for patient harm due to the increased prevalence of diabetes.

Can modern diabetes medication reduce gastric emptying?
As the market for diabetes drugs expands due to the increasing prevalence of diabetes, the pharmaceutical companies are developing innovative drugs to achieve glycaemic control. These include the development of the dipeptidyl peptidase inhibitors, e.g. sitagliptin and glucagon-like peptide
Conclusion
In summary, carbohydrate loading provides a useful adjunct to preoperative preparation; the potential for improving outcome is well recognised, with the reduction of insulin resistance and improved glycaemic control in the general population. However, a major concern is its potential deleterious effects on glycaemic control for those susceptible to hyperglycaemia. In all patients, the CBG must be tightly monitored and any resultant hyperglycaemia must be treated with insulin. Additionally, prior to administration, the potential risk of pulmonary aspiration must be considered.

Conflict of interests
Dr Fawcett has received travel expenses to attend symposia to discuss the benefits of carbohydrate loading; has received paid honoraria lecturing/book chapters/educational resources from Grunethal, Merck and Baxter; and is a ERAS® Society committee member.

Dr Levy has received travel expenses to attend symposia to discuss perioperative glycaemic control.

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21 Gustafsson UO et al. Pre-operative carbohydrate loading may be used in type 2 diabetes patients. Acta Anaestheticologica Scandinavica. 2008; 52: 946-951.
22 Sebranek JJ, Lugli AK, Coursin DB. Glycaemic control in the perioperative period. BJA. 2013 Dec;111 Suppl 1:S8-34.
Anaesthesia Research Innovation Education and Scientific (ARIES) Talks

Free, short, informative and entertaining talks from high profile speakers on areas of relevance to anaesthesia, critical care and pain medicine.

29 September 2016: Patient and public involvement, military anaesthesia and more
26 October 2016: Paediatric anaesthesia, anaesthesia in 25 years and more

For full details and to book a place, please visit www.rcoa.ac.uk/rcoa25
Election to Council 2017

Nominations for election to the Council of the Royal College of Anaesthetists are now open. There are the following vacancies:

- Three Consultant vacancies, open to Fellows
- One Trainee vacancy, open to Fellows by Examination of up to four years
- There are no SAS vacancies this year

Further details are available at [www.rcoa.ac.uk/election2017](http://www.rcoa.ac.uk/election2017) along with details of how to stand.

Council election timetable:

18 July 2016: Nominations opened:
Fellows and Members who wish to be nominated to stand were invited to download and submit forms available from the college website.

13 September 2016: Prospective Council Member information session (4-6 pm) – details below
Those interested in standing for election are invited to attend an informal briefing session.

30 September 2016: Nominations close
All completed nomination forms must be received by the chief executive's office.

30 September 2016: Finalisation of members’ details for ballot
Fellows and Members who have changed their email and/or postal address are requested to give notice to the membership team by emailing subs@rcoa.ac.uk by 16 September.

7 October 2016: Announcement of candidates standing
The names of the candidates and which category of vacancy they are standing for will be published on the College website.

24 October 2016: Ballot papers distributed
Ballot packs will be sent by post to the address registered at the College and via email. There will be an option to vote by ballot paper or electronically.

5 December 2016: Election closes
Ballots must be returned to Electoral Reform Services by 5pm.

6 December 2016: Result announced
The election results will be declared via the College website as soon as possible following the ballot count. The results will also be published in the President's e-newsletter and the College Bulletin.

7 March 2017: New members will be admitted to their first council meeting.

Contact Information:
Rose Murphy, PA to Chief Executive, Telephone: 020 7092 1612 or Email: ceo@rcoa.ac.uk

Information session for prospective Council members to Council 2017

13 September 2016
4–6pm

Those interested in standing for election are invited to attend an informal briefing.

Along with a question and answer session, the President and CEO will cover the commitment necessary to the role, an overview of College activities, committee work and projects. Please note that attendance at this session is not a prerequisite for standing for election. Email ceo@rcoa.ac.uk if you would like to come along.
Revalidation for anaesthetists

‘Top tips’ for the CPD systems

Chris Kennedy
CPD and Revalidation Coordinator

As the number of registered users for the College CPD Online Diary approaches 8,000 – and the CPD web app continues to average 1,000 visits per month – we would like to notify both new and existing users of both systems of some ‘top tips’.

These recommendations are based on feedback about both systems which have been received over recent months.

The CPD Online Diary was launched in August 2011 and since then details of over 4,000 events have been through the formal review process and approved for CPD credits, thereby appearing in the system. The overall aims and learning outcomes of these events, as well as the applicable codes from the CPD Matrix and the number of CPD credits available, are featured, meaning that the user only needs to add their reflective comments.

In view of the large number of events already on the system, it is always advisable to first search to see if the event which you attended has already been through the approval process (events can be searched for by title, date, event provider or keywords) so as to avoid duplication of effort in adding the event information again.

Focusing on the search options, in response to a request received that it should be possible to list all approved CPD events covering (as an example) paediatric anaesthesia, this feature has been added and can be used by selecting “Activities” and either “View and Subscribe to CPD Approved Events” (for future events) or “View Past Events”, and then choosing the appropriate code under “Filter by CPD Matrix Categories”. This search can be further refined to filter by coverage of a certain code over a defined date range.

We receive a number of enquiries from members requesting a change to their “Cycle” start date – the date from which they would like to start recording evidence of their CPD activities – usually as a result of a change in their appraisal date. Whilst the start date can easily be altered by contacting cpd@rcoa.ac.uk, the systems also allow for a report to be generated over a custom date range, for example an 18 month period if it has included a career break, and this can be done by using the “Filter by dates” option under “Reports” and “CPD Activity Summary”.

Some members have commented that the CPD systems should feature online learning courses. The current policy as agreed by the CPD Board is that formal approval is only available for external events (conferences, meetings, seminars, etc) where delegates attend ‘in person’. The interaction aspect of external CPD is that it presents an opportunity to meet and share ideas and examples of good practice with colleagues from outside the participant’s own organisation, which is not easily available through online learning. However, participation in on-line learning can and should be added as a “Personal Activity” on the basis of one CPD credit per hour of activity when accompanied by reflection.

Returning to the CPD event-approval process, we would like to remind all event providers that approval applies to the specific version of the event submitted, and does not automatically confer approval for all subsequent versions. When multiple versions of events are being held, one full evaluation needs to be completed by a CPD Assessor each year; thereafter, for the following 12 months it is only necessary for the event provider to submit the advert/flyer for each subsequent version, as long as the programme content and speakers are the same, in order for these to be added to the CPD systems and put on the College website.

We hope this information will be helpful. For further assistance with using the College CPD systems please contact cpd@rcoa.ac.uk.
Patient Perspective

Well, what do you patients want?

Rob Thompson
Chair, Lay Committee

There always seems a point in any meeting when someone turns to me and asks “well, what do patients want?”

I suppose it is a reasonable question. After all, I’m part of the Lay Committee (formerly the Patient Liaison Group) of the College, and in some way I’m supposed to be representing patients—or at least, potential patients.

The question was made even more compelling when I was taken to one side at a recent dinner and told by a senior member of the College, “don’t forget— you’re here to give the patient’s side of things.” Again, it is a very understandable expectation of the chair of the Lay Committee.

Yet the answer is not so easy. I could give a personal view, but how would that be any more valid than anyone else’s? I’ve worked in and alongside the NHS for over 40 years, but that fact may cloud my judgement and hamper my expectations of a service under all sorts of pressures. Also, how can I envisage the views of other patients — even less the needs of so-called ‘hard to reach’ groups of patients?

Part of the answer must be to look to the growing areas of work which pay attention to patient experience and satisfaction, in particular drawing on the evidence of the NHS Patient Surveys, which have been running for more than fourteen years. Those surveys focus on specific areas that are key to achieving person-centred care:

- Accessibility of care
- Communication, information and support
- Continuity and co-ordination of care
- Effectiveness of care
- Patient involvement and engagement.

These Surveys must be one of the most comprehensive, structured and systematic programmes examining patient experience in the world. They provide robust data on service issues that are important to patients and cover acute trusts across the NHS. The statistics do not provide satisfaction or approval ratings, but are a set of scores on those aspects of care that particularly matter to patients. Response rates are about 50%, meaning that the results are compelling, particularly as the programme provides robust data on service issues that are not easily measured by other means — e.g. staff behaviour, levels of involvement and provision of information.

Also, trends over the last ten years can be traced easily. I was most struck by the consistency of the scores over the last 9 years, as seen in Table 1 on page 12. Patients appear to be very consistent in their views about what they want.

When I searched out the summary of results on the NHS England website I was struck by the emphasis on statistical analysis, but also by the absence of action being taken to do anything about it. Perhaps that is not the role of that organisation. But what is even more disappointing is the little evidence I could find that the results are acted upon at all, either by individual Trusts or by the Care Quality Commission and similar.

How many Trust Boards espouse the mantra ‘Patient Centred Care’ but take no notice of this mine of information about what their patients care about? How often is the core of an inspection based on this database rather than merely the finances?

While the Surveys are very comprehensive, I’m still left feeling that they do not get to the heart of the matter. They seem like a ‘corporate’ response to what patients want.

I’m reminded of those meetings in the NHS when such matters were considered; everyone would pore through all the statistics and decide (or more likely not!) what to do about improving the patient experience. The meeting would then break up, and people would start to talk about the bad (or occasionally good) experiences of care that they or close family and friends had been through. These were talked about with a lot more passion and engagement than anything that went on in the previous meeting.

Comments like “you should have heard the way they were spoken to,” “thank goodness I work in the NHS or they would have said/done nothing” and “I had to get the doctor/nurse to deal with it all” were all commonplace.

So what is missing? In trying to get a bit closer to understanding this, I came across some qualitative research in the U.S. focussed on the perceptions of people who may not self-identify as patients. This ‘street study’ aimed to understand what people want from healthcare.
In the small study people were asked about their positive and negative experiences of healthcare and to explain the factors which made it such. Of the twelve themes identified, the three most cited as being critical to people’s experience of healthcare were:

■ Having a doctor who listens to them
■ Having healthcare professionals who are caring and compassionate
■ Having a doctor who explains things well

When people are asked about their healthcare experiences, they talk most often about the interactions between them and their doctor [and other healthcare professionals]. The patient-doctor relationship remains at the heart of people’s perception of healthcare.

The chart on the next page provides more details of the findings.

So what does this all mean?

First, a better informed response to the question “what do patients want?” I hope that, as members of the Lay Committee, we will become more research-focused and evidence-based in our approach to the subjects we consider.

Second, to start to look at using this qualitative data to inform the development of those areas of the College’s work where the patient experience is particularly taken account of, for example as GPAS goes through its redevelopment and this feeds into the ACSA standards.

Third, to support the College in developing better ways of training and developing doctors with first-class skills in communication.

And fourth, to support the College’s perioperative medicine programme, which addresses so many of the issues raised in both the quantitative and qualitative studies of what patients want.

I am concerned when I hear that some financially beleaguered trusts may be questioning the development of the perioperative medicine programme, on the grounds of saving money. Providing the right care at the right time in the right place must always be the most efficient and effective way—by reducing the amount of further treatment that patients require, reducing their lengths of stay in hospital, and ensuring that treatment is managed efficiently and coherently first time round. Perhaps we need to use the evidence of what patients want to press for the continued development of perioperative medicine, both locally and nationally.
Table 2 From “What Do People Want from Their Health Care? A Qualitative Study”: Results of thematic analysis for major contributors to positive and negative experiences in people’s health care.

<table>
<thead>
<tr>
<th>Contributor</th>
<th>% respondents</th>
<th>Representative comments</th>
<th>as per original study responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having a doctor who listens to them</td>
<td>85%</td>
<td>60F: “I like that my doctor always starts off my annual physical with what's going on in my mind... He turns the floor the patient. He asks wanting to know what my concerns are. This doesn’t feel like it is his program: it’s not focused on him, it’s focused on the patient... I like that because it’s about me as a patient and not automatic... he bends over backwards to keep care individualized” 67F: “My doctor listens everything about me: how does my medical problem affect me as a person, daily life, emotions, my family etc.” 72M: “I have a problem with my MD. He sends me off to lots of specialists and to get tests before he even listens to everything I have to say. It seems like he doesn’t even listen to what my whole problem is. He could maybe solve it himself.”</td>
<td></td>
</tr>
<tr>
<td>Having a doctor who explains well</td>
<td>69%</td>
<td>49F: My doctor will explain me if I have a problem what it is, what we do when it happens and exactly what’s wrong with my body. Doctors need to give details of why you’re sick, what makes it better, and how your medicine is going to work.” 24F: “I love my doctor... she translates things so that a normal person like me and you can understand them.” 75M: “Even when you’re at the hospital, they don’t really explain anything to us. If they are sending me to a referral specialist, they should at least tell me why.” 22F: “I don’t like my own doctor. I go in for a sore throat and she tells me I’m fine. She trivialized my complaints. She doesn’t share her thought process.”</td>
<td></td>
</tr>
<tr>
<td>Having convenient and quick access to health care</td>
<td>47%</td>
<td>77M: “In my country, we only go to see the doctor when we're sick. Here I feel like we have to go all the time. But when you’re at your sickest, the doctors are not available for you”. 69F: When the MD says follow up in 2 weeks, and then they don’t have an opening in the schedule for 2 weeks, what do I do?”</td>
<td></td>
</tr>
<tr>
<td>Having a doctor who is caring and compassionate</td>
<td>71%</td>
<td>58F: “My doctors cares a lot about people. It’s obvious. She cares for all kind of people. I have known her for 20 years. I came here without insurance and she still helped me.” 23M “I would want their doctors to have compassion and show my loved one that they care about them as a human being, not just as another case to solve”. 74F: In the office, she remembers you, your family asks about my grandson, great-grandkid, even if they are not her patients. She has many patients but still manages to remember each one and details. My great granddaughter has a heart defect. She’s not my GP’s patient. But every time I go to a checkup, my GP asks me how her progress is. She welcomes you with a big smile, makes you feel like you are a part of the family... it makes me feel confident that she wants to learn from you. My insurance doesn’t cover her but i pay her out of pocket because I like her.” 72F: If I could ask to improve something, I would say stop ignoring me. I feel invisible. Is it because I’m older? Doctors need to care about their patients.” 71F: I really didn’t like this one doctor. He didn’t even look at my face. He kept walking. I felt discriminated against because maybe he didn’t talk to me because my English isn’t so fluent and I’m old. He didn’t care.”</td>
<td></td>
</tr>
</tbody>
</table>
Anaesthesia Clinical Services Accreditation

National recognition for ACSA standards and regional engagement

Sharon Drake
Director of Clinical Quality and Research

Charlie McLaughlan, Director of Clinical Quality will be known to many of you as the Director with managerial responsibility for Anaesthesia Clinical Services Accreditation (ACSA) at the College. As the incoming Director, I’d like to take the opportunity to highlight some of the successes we’ve achieved over the last three months, and explain how we have, and will continue to build upon the excellent work Charlie initiated. With one-third of hospital departments already engaged with ACSA, there is much to build upon.

Our standards

The 2016 ACSA standards were published in May, and these replace the 2015 ACSA standards. There are 151 Domain 1-4 anaesthesia standards (reduced from 171), and these now include paediatric standards.

The standards are reviewed and updated annually, and following this year’s review we have been able to streamline the number by improving the clarity of some of the standards and evidence required, as well as removing any duplication.

The ACSA Domain 5 sub-specialties (Cardiac, Neuroanaesthesia, Vascular and Ophthalmic) are all complete and can be viewed at http://bit.ly/2aIBWgC. Domain 5 can be undertaken alongside Domains 1-4.

National recognition for GPAS

GPAS includes three chapters developed using NICE’s rigorous evidence-based process:

- Guidance on the provision of emergency anaesthesia services.
- Guidance on the provision of anaesthesia services for preoperative assessment and preparation.
- Guidance on the provision of anaesthesia services for postoperative care.

The NICE process used to produce these chapters is systematic and transparent, and considers the strength of the evidence and the balance of risks and benefits. Individuals from all relevant stakeholder groups, including lay representatives and other medical professions, were involved in the development of the chapters. The first chapters chosen to go through the NICE process are core to the delivery of a
quality anaesthetic and perioperative service, and the new process will be rolled out for all remaining chapters over the next three years.

The achievement of this quality marker will ensure ACSA continues to reference the highest standards, and our continued commitment to enhancing and improving GPAS will ultimately result in improved levels of patient care and safety as delivered within our anaesthetic departments.

Regional engagement
Enhancing member engagement in the regions is a key priority for the College, and so I was pleased to be in post for the first regional ACSA event at Whiston Hospital, Prescot on 6 June. The day was hosted by the St Helens and Knowsley anaesthetic department, and developed and designed by Dr Tushar Dixit, Dr Kate Glennon and Dr Samantha Pedder. St Helens and Knowsley Teaching Hospitals NHS Trust recently gained accreditation in February 2016 and were able to share the benefits of their experiences with neighbouring hospitals and colleagues.

It was clear from the feedback that participants appreciated hearing how others had achieved accreditation. However, more specific examples were requested on how some of the standards could be achieved, and we will continue to develop our library of good practice to support these requests.

Feedback from these interactive events provides real insights into how departments are preparing for accreditation, and offers many practical tips on how to break down the standards into achievable, ‘bite-size chunks’. This was reiterated at our College Tutors’ meeting in Brighton in June where the key messages from Dr Justin Turner from Salford Royal Foundation Trust were:

- Assign responsibilities for sections of ACSA to individual doctors from the outset.

There is still much more to achieve and we cannot be complacent. Our recent membership survey showed that approximately one-third of respondents were not aware of ACSA and just under a quarter did not think it was applicable to them. We clearly need to do more to promote ACSA, and putting you in touch with those who have already achieved ACSA accreditation through national and regional events is clearly a successful way to do this.

I will be working closely with our experienced ACSA team over the next three months to look at how we continue to expand and engage with departments throughout the UK, and how we can better support you to meet the standards. Please do share your views and ideas at http://bit.ly/2a2vFhF.

For further information please contact: ACSA@rcoa.ac.uk or telephone 0207 092 1697
The Faculty of Pain Medicine

Update from Professional Standards Committee

Beverly Collett, Chair

Core Standards for Pain Management Services in the UK (CSPMS UK)

CSPMS UK was launched in parliament, courtesy of Lord Richard Luce, and published in November 2015. Endorsed by all healthcare professions involved in acute, chronic and community pain management services, this collaborative document should drive forward service improvements and enhance the availability of multidisciplinary care needed by patients with persistent pain. The College of Paramedics is keen to develop standards for out of hospital management of pain by paramedics, and a chapter is in development. A meeting was held with Claire Land from the Care Quality Commission (CQC), and key core standards were identified for the management of pain in urgent and emergency care, medical care, surgery, critical care, maternity and gynaecology, services for children, young people, neonates and transition, outpatients and diagnostics and end of life care. These were officially adopted by the CQC for use in inspection visits. The key standards can be downloaded from the website.

Other news

The Faculty has developed a safety checklist, “Interventional Pain Procedures under local anaesthesia or sedation”, that is adapted from the WHO surgical safety checklist and is accessible on the FPM website at http://bit.ly/29doM8p. This may be useful to departments of anaesthesia and pain medicine when developing local templates.

Neuraxial procedures (interlaminar or transformaminal epidural injections of corticosteroids) either in the lumbar or cervical regions, are procedures commonly performed by consultants in pain medicine, but also occasionally by anaesthetists or radiologists for upper or lower limb radicular pain. There is international debate regarding the safety and efficacy of particulate and non-particulate preparations. There is a growing awareness of the complexity of informed consent appropriate to the clinical circumstances of the patient. The FPM and the British Pain Society are developing an informational consent statement to aid those practitioners performing these procedures.

EPM: The Essential Pain Management (EPM) programme was originally developed as an educational tool for healthcare workers in lower income countries. EPM Lite is a scaled-down version of the full course, designed to be delivered to medical undergraduates in half a day. The FPM took on the task of introducing EPM Lite. The first UK course was held in Bristol in September 2014. The course helps students understand classifications of pain, why pain should be treated, and gives an overview of different drug and non-drug treatments. The half-day course is flexible, and the content and timings can be amended to suit group size and level of teaching. It has been delivered in 11 UK medical schools in a variety of guises: weekly one-hour sessions, during students’ Anaesthesia Specialty Study modules, and as part of a final year course in preparation for FY1 posts. Is this something that your medical school would be interested in? For more information, see http://bit.ly/29dp0ML.

Quality consultations: The Committee identified the need to set standards in consultation in pain medicine, expanding on the regulatory guidance published by the General Medical Council in “Good Medical Practice”. This resulted in the recently published FPM document “Conducting Quality Consultations in Pain Medicine”. On a platform of raising standards, we have initiated a conversation on whether consultation training should form an integral part of Pain Fellowship training and, if so, how that can be put into action.

Having established what the components of a quality consultation should be, we are also now approaching the complex and highly problematic issue of how much time should be allowed to do this by an atomised analysis of a sample of new patient consultations.

It has been a tremendous privilege to be Chair of this Committee. I have enjoyed the opportunity to increase liaison with anaesthetic colleagues, and to discuss common areas of interest and concern. I am delighted to be handing over to Dr Paul Wilkinson, who has already been proactive in many aspects of this Committee’s work and I am sure will maintain good future collaboration.


The Faculty of Intensive Care Medicine

Recruitment, e-Learning and the website

Daniel Waeland
Head of the Faculty of Intensive Care Medicine (FICM)

The Quality, Recruitment & Careers Sub-Committee approached this round of national recruitment with some trepidation, as I’m sure the whole profession did, with the junior doctor contract discussions in full flow. We knew application rates were slightly lower than in the previous year and there was always the risk this would impact on fill rates. Fortunately, we finished this year’s recruitment with a higher fill rate than 2015: 90%.

This was all the more of an achievement for the new specialty, as the number of posts was at another year-on-year high of 158. This is well over double the 72 posts the Faculty started with back in 2012. The fill rate masks a slightly different regional picture, with some regions oversubscribed but unable to appoint existing partner specialty ST3 trainees due to the small number of deanery-approved posts available. The majority of regions filled either all or all but one of their slots.

In consequence of the above, the Faculty had the pleasure of welcoming 140 new trainee doctors into the specialty in 2016. Recruitment took place over three days, with 240 candidates invited for interview including some Defence Medical Services interviewees. The Hawthorns football ground again played host to the interviews, having both plenty of room and plenty of parking. Health Education West Midlands ran our recruitment for the fifth consecutive year, and we are very thankful to Tom Melia and his team for their hard work. Helping to construct the intricate timetable for the 70-plus interviewers over the three days, and generally being a font of knowledge and support, was Susan Hall from the FICM Department.

e-ICM

The Faculty has received funding from e-Learning for Healthcare (e-LfH) to produce an e-learning resource for Intensive Care Medicine (ICM). Pete Hersey (Clinical Lead) and Sarah Marsh (Deputy Clinical Lead) have been working closely with Ed Hammond (e-LA Clinical Lead) and Ali Hall (e-LA Editor for the critical care module) to map out the structure for this new project, which will feature both new content and re-ordered existing content from across a number of e-LfH programmes, naturally including a sizeable chunk from e-LA.

The project will cover Stage 1 of the ICM curriculum and will be helpful for those studying for the FFICM Examination, as well as for multiprofessional colleagues. If all has gone to plan, by the time you are reading this, the first modules from e-ICM will have just launched, with further modules to arrive over the coming months.

New website

By the time this edition of the Bulletin reaches your desks/doormats/computer screens, the FICM will have launched its new website. The (now) old FICM website was a swift solution to our need for a web presence when the Faculty was first launched, being the existing Intercollegiate Board website with a new skin added. As the FICM has grown and flourished over the intervening six years, so too has the content of the website, and the old structure was beginning to creak and groan under the weight of it.

The new website aims to make finding information on the website much easier, both for regular and occasional visitors. In common with most websites (including the College’s), it features a top-level ribbon under which areas are grouped, with a side-panel menu. In addition, the search function has been improved, and there is a ‘Popular Pages’ section at the foot of the homepage which has ten key links for different groups accessing the website (General, Consultants, Trainees, Advanced Critical Care Practitioners, and Patients & Relatives). Do check any links you have from your own websites to www.ficm.ac.uk as URLs will have changed during the move. If you have any feedback, do let us know.
Health Services Research Centre

What you need to know from the Second NELA Patient Report

Dave Murray
NELA National Clinical Lead
Consultant Anaesthetist, James Cook University Hospital, Middlesbrough, UK

The Second Report of the National Emergency Laparotomy Audit (NELA) was published in July 2016 (www.nela.org.uk). The Report contains data on more than 23,000 patients, bringing the total in the NELA dataset to over 44,000 patients. This article summarises the main findings about delivery of care and patient outcomes.

Has there been improvement in care since the First Report?

Yes, and clinicians should be proud of their commitment to NELA, since that commitment has led to more patients now receiving care that meets standards in more hospitals. There are several time series graphs within the NELA Report, (for example, Figure 1) that show an upslope in the trend line that coincides with the dissemination of the findings from the First Patient Report. Improvement has generally taken place in areas that require change at the level of individual clinician and team behaviours.

- Case ascertainment improved from 65% to 70%, meaning we can be fairly confident that the findings are representative. However, our contractual case ascertainment target increases to 80% for the current data collection period that runs until November 2016.
- CT scanning and reporting before surgery improved from 68% to 72%.
- Preoperative risk assessment improved from 56% to 64%. Standards of care were again more likely to be met when risk had been assessed.
- Consultant surgeon and anaesthetist presence in theatre improved from 65% to 70%, with similar increases for high-risk patients (i.e. predicted mortality >5%). Consultant anaesthetists were present for 82% of high-risk patients, and consultant surgeon 89%. However, there are still differences between in-hours and out-of-hours presence.

There has been less improvement in areas that require change at an organisational level, and rectifying this will require greater engagement

Figure 1 Trend in the overall proportion of patients whose risk of death from surgery was documented preoperatively
between clinicians, managers and commissioners.

- There has been little change in access to theatres, with 82% of patients arriving in theatre within a timeframe appropriate to surgical urgency. The most urgent group (surgery within two hours) fared worst with only 70% arriving in time.
- Critical care admission for highest-risk (>10%) patients has remained at around 85%.
- Input from Elderly Medicine specialists was provided for only 10% of patients over 70 years old.

**Hospital-level care**

Due to the heterogeneity of the patient population, it is not appropriate to expect 100% compliance with all standards. The NELA Report uses a RAG (Red-Amber-Green) rating to report the extent to which hospitals meet standards of care. At present, a “green” rating is given if a hospital meets a standard for at least 80% of patients, representing reliable delivery of good quality care. Whilst the overall proportions of patients receiving care that met standards has improved, the picture is slightly different when examined at hospital level. Whilst the numbers of hospitals rated “green” has improved (Table 1), there is still considerable scope for improvement (Figure 2). Many hospitals are already meeting standards for 60-70% of patients, so effort directed towards these areas is likely to be worthwhile. Over time, the threshold for a “green” rating is likely to move towards 90%, especially for those areas which look at standards in a more defined patient population (e.g. preoperative assessment of risk).

**Table 1** Comparison of change in the number of hospitals rated Green (standard achieved for ≥80% of patients) for each key process measure between the First and Second NELA Patient Reports

<table>
<thead>
<tr>
<th>Process Measure</th>
<th>Number of hospitals rated Green</th>
<th>Change (+ve represents improvement)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First NELA Patient Report</td>
<td>Second NELA Patient Report</td>
</tr>
<tr>
<td>CT scan reported before surgery</td>
<td>50</td>
<td>67</td>
</tr>
<tr>
<td>Risk assessment before surgery</td>
<td>25</td>
<td>43</td>
</tr>
<tr>
<td>Arrived in theatre within appropriate timeframe</td>
<td>133</td>
<td>129</td>
</tr>
<tr>
<td>Preoperative consultant surgeon and anaesthetist involvement for patients with</td>
<td>24</td>
<td>26</td>
</tr>
<tr>
<td>a preoperative P-POSSUM risk of death ≥5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant surgeon and anaesthetist present in theatre for patients with a</td>
<td>65</td>
<td>83</td>
</tr>
<tr>
<td>preoperative P-POSSUM risk of death ≥5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant surgeon present in theatre for patients with a preoperative</td>
<td>155</td>
<td>158</td>
</tr>
<tr>
<td>P-POSSUM risk of death ≥5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant anaesthetist present in theatre for patients with a preoperative</td>
<td>96</td>
<td>112</td>
</tr>
<tr>
<td>P-POSSUM risk of death ≥5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest risk patients (P-POSSUM risk of death &gt;10%) admitted directly to critical</td>
<td>126</td>
<td>138</td>
</tr>
<tr>
<td>care after surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients aged of 70 years or over assessed by an Elderly Medicine specialist</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
consultant presence in theatre for high-risk patients, and admission to critical care for highest-risk patients).

Outcomes
Overall 30-day mortality was 11.7% in Year 1 and 11.1% in Year 2. Figure 3 shows how mortality has changed over time, and there are encouraging trends. We finally received independently verified Office of National Statistics (ONS) mortality data, and one of the key inclusions in this Report was risk adjusted hospital-level mortality. Whilst reassuring that there were no statistical outliers, this needs to be taken in context. Risk adjusted hospital-level mortality ranged from 5% to over 17%. The variation in the extent to which standards of care were met suggests that there is considerable scope to improve outcomes by improving care to meet standards.

Mean length of stay is almost two days shorter in Year 2 compared with Year 1. The cost savings in ward care alone are estimated to be around £22 million. This is a significant finding, as it means that hospitals should see financial advantages in improving patient care, and can help win the argument that it is worthwhile investing in improved resources.

Additional information on variation in mortality according to, for example, age and surgical urgency is included in the Report, as well as information on hospital-level variation in patients returning to theatre and unplanned admission to critical care.

Risk prediction and P-POSSUM
The majority of clinicians are familiar with the use of P-POSSUM to assess risks of surgery. The availability of ONS data has allowed us to determine the accuracy of risk of death assessments provided by P-POSSUM. It is reasonably accurate below around 15% mortality. However, above this level P-POSSUM tends to overestimate risk. This is illustrated in Figure 4. From a clinical perspective, P-POSSUM is still useful for identifying patients who fall into a lower-, high- or highest-risk category, in order to make decisions about the need for resources such as critical care. However we would urge caution in reliance on P-POSSUM when used to guide clinical decision making at high levels of predicted mortality, as it overestimates risk of death by a factor of approximately two. The wealth of data within NELA should allow us to develop a more accurate risk prediction tool that is specific for emergency laparotomy patients.

The future
The Report makes 12 key recommendations for commissioners, hospital boards and clinical teams aimed at addressing shortfalls in care. Whilst NELA is an “audit”, it is clear that using quality improvement (QI) methodology will bring about the fastest improvement. The NELA QI Dashboard https://data.nela.org.uk/Reports.aspx supports this by making local data instantly available. We will be supporting this in the coming months with additional educational material to enable more clinicians to understand how to use data to drive improvement.

Engagement by frontline staff has been essential in getting NELA to its current position. This is highlighted by the improvements in patient care brought about by changes in how clinicians personally provide care. We are optimistic that we will see continued improvement as NELA progresses, but this will require continued and concerted effort by all.
Perioperative Quality Improvement Programme

Working together to improve patient outcome

Ramani Moonesinghe
Consultant in Anaesthesia & Critical Care
Director NIAA Health Services Research Centre

PQIP is coming to a hospital near you this Autumn. This exciting new national project will measure quality of care and patient-centred outcomes – complications, recovery and health-related quality of life – after adult elective surgery in any hospital which undertakes major colorectal, upper GI, thoracic, hepatobiliary, head and neck or urological surgery.

What are our challenges?
We know how much effort clinicians put into collecting data for projects like this. We know too that time is precious, and increasingly job plans and trainee schedules are being squeezed, reducing time for these initiatives.

We hope that by working together we can overcome some of these challenges. For example:
- PQIP data can be entered on internet-enabled mobile devices; this should support clinicians entering data while they are in the operating theatre.
- We will provide automated run-charts and other feedback of local results so that you can see how your patients and your team are doing.
- We will provide regular reports targeted at different people within your team – e.g. managers, surgeons, anaesthetists.

What’s in it for you?
We will soon confirm details of surgical, anaesthesia, management and QI leadership in all hospitals that will be in the first wave of participants. Each role is accompanied by a job description which can be used locally to support appraisal, job planning and revalidation discussions. These roles will be supported with opportunities to access training and support (both online and face-to-face).

The data entry website should support you with your personal goals. For example, if you are a registered PQIP user, you will be able to access your hospital’s local data to help you monitor processes and patient outcomes, and you will be able to access easy links from particular data points to the RCoA’s QI compendium and GPAS documents (so enabling you to easily find support for small QI projects which you can lead on specific processes and outcomes).

Above all, we want participation in PQIP to be fun, and to feel like something you want to be part of, not a chore or yet another demand on your precious time. The RCoA and HSRC have a responsibility to support you to engage with this, and we hope that we can rely on your support in delivering this important project which will improve outcomes for thousands of NHS surgical patients. Find out more from our website: www.rcoa.ac.uk/pqip or by contacting us at pqip@rcoa.ac.uk

TOP TEN KEY POINTS

1. Around one in ten patients have serious complications after major surgery.
2. These complications can affect long-term quality of life and survival.
3. There are currently no national data about the rates of complications in different hospitals or how effectively we treat them.
4. Data from the USA demonstrate huge variation in whether patients survive with good outcomes after developing complications.
5. PQIP will measure these outcomes and support clinicians to use data to improve them.
6. We will focus on major adult elective surgery and all NHS hospitals are welcome to take part.
7. Hospitals will be asked to submit data on a random sample of up to five patients per week.
8. All patients will be required to give consent to take part.
9. We hope that this study will be adopted onto the NIHR portfolio, so enabling hospitals to get research nurse support for patient recruitment and data management – confirmation will come over the summer.
10. The HSRC and RCoA want to support you in using the data you collect for real quality improvement locally: we are developing a suite of videos, podcasts, and other support mechanisms to help with this.
National Institute of Academic Anaesthesia

Future strategy

Monty Mythen
Chair, NIAA Board

Rob Sneyd
Chair, NIAA Research Council

The National Institute of Academic Anaesthesia (NIAA) maintains a constant discussion with its four founding partners – the Royal College of Anaesthetists, the Association of Anaesthetists of Great Britain & Ireland, the British Journal of Anaesthesia and Anaesthesia – on its forward strategy. The NIAA has grown considerably in stature and influence since its founding in 2008 – over £6.6 million in grants and other funding has been awarded by the NIAA across its lifetime. The continuation of this growth is the aim of the NIAA’s future strategy and is a testament to the commitment to academic anaesthesia on the part of not only the four NIAA founding partners but also the numerous other funding partners who contribute to NIAA grant-rounds.

The current iteration of our strategy encompasses both work underway since 2015 and the future development of the NIAA over the next few years. It is important to note that the NIAA’s strategy is underpinned at all times by:

■ OUR VISION: To improve the health of patients and the public through research and innovation.

■ OUR MISSION: To promote, support and deliver world-class biomedical and health research in anaesthesia, perioperative and pain medicine.

To that end, across 2015-2020, the activities and resources of the NIAA are focused on delivering four strategic aims. Please note that the aims below, whilst broadly encompassing all areas of activity, have been necessarily abridged for publication space: a more detailed description of each strategic area can be found at www.niaa.org.uk.

AIM 1: Develop high-quality collaborative research through the NIAA Perioperative Medicine Clinical Trials Network

We will support and promote the work of the Clinical Trials Network (CTN).

The CTN will:

■ Create groups of suitably trained Principal and Local Investigators across the UK and identify and create training, communication and networking opportunities for trial investigators at all levels.

■ Develop a Chief Investigator training and mentorship scheme.

■ Publicise the CTN as a new opportunity for all investigators and anyone interested in engaging in clinical research in perioperative medicine.

We will continue to support the Quality Audit and Research Coordinators in sharing information on local issues.

We will increase engagement with the National Institute for Health Research (NIHR) Clinical Research Network (CRN) by:

■ Increasing the number of NIHR portfolio studies, and maximising the value of matched funding from the NIAA by utilising the CTN.

■ Creating close links with the CRN National Specialty Lead and Regional Specialty Leads in anaesthesia, perioperative medicine and pain medicine.

AIM 2: Develop and promote trainee involvement in national and regional research and audit

We will support and promote the work of the Research & Audit Federation of Trainees (RAFT) and associated Trainee Research Networks (TRNs) by:

■ Encouraging the creation of TRNs in regions where none currently exist and providing mentorship and support to fledgling TRNs.

■ Encouraging RAFT engagement with the NIHR portfolio, including RAFT ‘adoption’ of portfolio studies.

■ Encouraging support to regional TRNs in the development of sustainable, multi-centre audit and quality improvement projects.

We will promote the ‘Research Aware–Research Ready–Research Experienced’ education model by:

■ Using the NIAA Academic Training Coordinator to oversee promotion of research training, develop approved research fellowships, and coordinate research meetings.

■ Supporting parallel training pathways toward careers for university-based academics and research-active NHS consultants.

■ Working with the Royal College of Anaesthetists to update and support academic components of
AIM 3: Award grant funding to research and researchers of the highest quality based on the NIAA vision and mission

We will create an environment where anaesthetists in training can make full use of high-level government and charitable funding opportunities.

We will support the early career development of trainees who wish to pursue academic training, by:
- Investigating ways of securing matched funding for career development grants.
- Continuing to offer the John Snow Intercalated BSc Awards for medical students.

We will support NIAA mid-career/career development grants for research professionals and postdoctoral researchers by:
- Continuing to provide fellowships through the Health Services Research Centre (HSRC).
- Encouraging other organisations to develop research fellowships.
- Developing good practice guidance for fellowships.
- Establishing a national strategy for local quality assurance of research fellowships.

We will promote and communicate research and career development opportunities as widely as possible through all available NIAA channels, events and external organisations.

AIM 4: Facilitate increased funding for and strategically invest in national health priority areas as defined by patients, public and the professions

We will communicate the ongoing need for high-quality biomedical and clinical research in anaesthesia by:
- Seeking further joint funding initiatives with high-profile bodies, such as the Department of Health, NHS England, NHS Scotland, NHS Wales, NHS Northern Ireland; the NIHR, the Medical Research Council, the Francis Crick Institute, the Wellcome Trust, and the Medical Royal Colleges.
- Promoting the appointment of academic anaesthetists to research funding panels and the boards of major funders.

We will encourage the awarding of grants in accordance with defined priorities, such as the military, the James Lind Alliance Priority Setting Partnership (JLA-PSP), and specialist society priorities.

We will produce NIHR Health Technology Assessments based on the JLA-PSP priorities and encourage specialist societies to submit proposals and vignettes for NIAA support.

We will continue to support and work closely with HSRC.

We will continue to support joint NIAA and Royal College of Surgeons initiatives and joint meetings.

We recommend that any readers interested in the work of the NIAA should read the NIAA Comprehensive Review 2014-15, the latest in the Institute’s series of biannual reviews, which covers in detail the work of the NIAA over that period and shines a light on some of the success stories of NIAA funding. The Review can be downloaded via www.niaa.org.uk or a hard-copy requested from the College.

If you would like to get in touch with the NIAA or join our mailing list to be kept abreast of further developments, please contact info@niaa.org.uk.
In October 2015, I was asked by Professor Monty Mythen, Chair of the NIAA, to lead on the development of an NIAA Research Award to be presented at the inaugural NIAA Annual Scientific Meeting on Thursday 14 April 2016 at the Royal College of Anaesthetists.

Taking reference from the ICM Gold Medal Award, I produced the initial draft of Award guidance: aims, eligibility criteria, application process, selection and presentation and judging. The RCoA agreed an honorarium of £500 for the winner and £250 for the runner-up prize.

The Award was open to all current UK researchers in anaesthesia, perioperative medicine and pain medicine. Applicants were invited to submit a summary of their body of work – typically the equivalent to two or more research papers on one subject area or from a higher degree thesis (MD/PhD).

Seven applications were received by the closing date. Professor Mythen suggested a panel of reviewers who would score the applications, decide on a shortlist and judge them at the Award session. Applications were ultimately scored by two reviewers – Dr Andrew Klein, Anaesthesia Editor-in-Chief and Dr Brian Jenkins, Anaesthesia Editor. It was decided to invite all seven applicants to present on the day - since this was the inaugural Research Award it was felt to be important to remain inclusive.

The seven shortlisted finalists were:

1. Dr Edward Gilbert-Kawai: Microcirculatory blood flow in hypoxia: a comparative study between Sherpas and Lowlanders; UCL.
2. Dr Sam Huddart: The emergency laparotomy quality improvement care bundle (ELPQuiC); Surrey.
3. Dr Raja Jayaram: Myocardial nitroso-redox balance and postoperative atrial electrical characteristics following cardiac surgery on cardiopulmonary bypass: Translational implications for perioperative statin therapy; Oxford.
4. Dr Simon Lambden: Of mice and men... and monocytes: a translational approach to understanding the role of dimethylarginine dimethylaminohydrolase 2 in sepsis; Imperial College London.
5. Dr C Matt Oliver: Mechanisms underlying inter-hospital variation in patients’ outcomes after emergency laparotomy in England and Wales - a structure, process and outcome analysis; NIAA HSRC.
6. Dr Jaimin Patel: Statins in sepsis – investigating the role of simvastatin in the modulating neutrophil function in healthy ageing and sepsis; Birmingham.
7. Dr Pervez Sultan: Acquired hypometabolism in lymphocytes underlies postoperative immunosuppression and risk of infection; UCL.
Competition
On 14 April 2016, all seven finalists made their presentations to delegates attending the NIAA Annual Scientific Meeting. The Research Award session was chaired by myself, and the presentations were judged by Professor Rupert Pearse, the NIAA Clinical Trials Network Director, along with Dr Andrew Klein and Dr Brian Jenkins.

All shortlisted candidates gave excellent presentations of their research work that were enthusiastically received. The final results were:

Runner-up – Dr J Patel for his presentation "Statins in sepsis – investigating the role of simvastatin in the modulating neutrophil function in healthy ageing and sepsis.”

Winner - Dr P Sultan for his presentation "Acquired hypometabolism in lymphocytes underlies postoperative immunosuppression and risk of infection.”

Feedback and learning
Although the event was overall a success, we realise there could be some points to learn for next year. I worked with the Research Award runner-up Dr Jaimin Patel to produce an online survey for the finalists, to gather their feedback. Six of the finalists responded to the survey and the results were very positive overall; all respondents felt that the structure of presentations and the Research Award guidance were appropriate and helpful. However, there were some comments suggesting that there were too many presentations and some inconsistencies from the judging panel. We will learn from these points in planning next year’s event, which we hope will be even bigger and better.

Congratulations to all finalists especially to Dr Patel and Dr Sultan, and thanks to all who were involved in contributing to the event, particularly the Award judges Prof Pearse, Dr Klein and Dr Jenkins for their help in setting the NIAA Research Award off to a great start.

CLINICAL TRIALS NETWORK LAUNCH
Joyce Yeung, University of Birmingham

On 14 April 2016, the much anticipated UK Perioperative Medicine Clinical Trials Network (UKPOMCTN) was officially announced during the NIAA Annual Scientific Meeting by Professor Rupert Pearse. The objective of the Network is to create an environment which allows everyone with an interest in perioperative care to make a meaningful but realistic contribution to clinical trials and observational studies.

The meeting started with a look into the future – ‘The changing landscape of perioperative research’ by Dr Ramani Moonesinghe (Director, Health Services Research Centre), followed by a masterclass in the art and craft of clinical trials by Professor Ian Roberts. We were also joined by patient and public representatives, Ms Marion Cumbers and Mrs Jacqui Gath, who reminded us of the important lessons from our patients.

The nuts and bolts were introduced by the Network’s board members: Dr Matt Wilson explained how the Network will select new trials, Dr Phil Moore described how tomorrow’s Chief Investigators will be supported and developed, and Dr Michael Gillies outlined the expectations and what it means to become a member of the Network.

By creating working relationships between trial organisers and investigators in individual hospitals, the UKPOMCTN will support large collaborations, and promote local engagement and early implementation of study findings.

The first UKPOMCTN meeting will be held on 9 November 2016 at The Studio in Birmingham. There will be a mixture of research training and also proposals for upcoming perioperative medicine studies. Do come and join us to find out more www.rcoa.ac.uk/node/22983
In 2015, the Board of the National Institute of Academic Anaesthesia decided to form a Perioperative Medicine Clinical Trials Network (CTN) to develop, support and co-ordinate world-class multi-centre clinical trials in the UK. The core purpose of the CTN is a simple one: to support the generation of new evidence to inform the care of more than 300 million patients undergoing surgery worldwide each year.

It is now well recognised that complications after surgery result in significant delays in patient recovery and return of functional independence. Patients who develop postoperative complications experience a higher mortality risk, which persists for many years after surgery. Improvements in perioperative care may therefore have a substantial impact on wider public health, and the Royal College of Anaesthetists has responded to this challenge by launching the Perioperative Medicine Programme.

Until recently, we lacked any organised system in the UK to design and conduct medium- and large-scale clinical trials in perioperative medicine. Despite this, we have seen a significant increase in patient recruitment to large clinical studies. UK researchers have either led or made major contributions to several major multi-centre studies, including POISE, ENIGMA II, OPTIMISE, EuSOS, ISOS, RELIEF and METS. These successes demonstrate our enthusiasm to contribute to large-scale research projects in anaesthesia and perioperative medicine. It is now the ideal time to formalise these collaborations through the creation of a national clinical trials network, to ensure the UK can play a leading international role in clinical effectiveness research in this field. The CTN will help primarily by building infrastructure to facilitate patient recruitment into clinical trials. By far the most important aspect of this infrastructure is an engaged community of investigators in individual hospitals who have access to a national forum to shape the research agenda, as well as supporting its delivery.

What will the clinical trials network do?

The CTN is creating an environment which allows everyone with an interest in perioperative care, from all the relevant professional backgrounds, to make a meaningful but realistic contribution to clinical trials and observational studies. In practice, we are inviting new members to join one of two main schemes – the Local Investigator scheme and the Principal Investigator scheme. The
purpose of this distinction is mainly to ensure that we send invitations to participate in trials to experienced local leaders. Most of the CTN activities will be directed equally at members of both schemes. To be a CTN member is much more than to have your name on a mailing list. You will need to provide basic evidence of research-readiness to join, such as a Good Clinical Practice (for research) certificate, and you will need to renew your membership every two years. Our aim is that all members will be active on at least one CTN-adopted study in that period, although we will need to take into account the fact that not every member will have the opportunity to do so. In return for their contribution, investigators will be given a much greater sense of ownership of our projects, many of which will have been developed as new ideas within the network, and will be led by our members. We will organise at least two meetings each year to ensure that members are the first to hear about development projects, and about the full-scale trials we will need help with. To give members the opportunity to provide feedback, every adopted trial will be presented at least once at a CTN meeting before patient recruitment commences. The CTN should not be confused with the NIHR UK Clinical Research Network www.crn.nihr.ac.uk, which is a national organisation providing infrastructure, in particular funding for research nurses, to support clinical research in all medical areas.

What type of research will the CTN focus on?
The CTN will primarily support research projects involving the recruitment of patients, where the aim is to improve outcomes following surgical treatment. This will not usually include research into surgical techniques, except where there is clear overlap with perioperative medicine. The primary focus will be on large clinical trials (500+ patients), but some smaller studies will be appropriate for CTN adoption, especially if these are likely to translate into subsequent larger trials. Clinical trials in intensive care medicine are already well served by the Intensive Care Foundation and the CTN would avoid research in this area unless it is relevant to perioperative medicine.

Progress so far
I am privileged to have been appointed founding director of the CTN in June 2015. We established a working group to develop the project, and the executive board has now been appointed with broad stakeholder representation. The CTN launched officially in April of this year at the NIAA Annual Scientific Meeting, and you can watch the webcast at www.rcoa.ac.uk/webcast-catalogue. New members are now able to apply to join either the Local Investigator scheme, or the Principal Investigator scheme from the CTN website www.pomctn.org. We have already received more than 100 applications for membership from trainee and senior doctors, and nurses and other allied health professions. Plans for the Chief Investigator scheme are almost complete, and this will launch in the autumn. Ultimately, new CTN projects will be selected from proposals made by the network membership. Investigators will be free to join and then propose a new trial, but a track record of contribution to network activities will be one of the criteria considered in the adoption process. We will also have a separate process to allow us to tender for commissioned research calls. Meanwhile, we have an interim process for study adoption within the first 24 months of the CTN, and the first trial proposal to be adopted under this process was the COMMAS trial; a pragmatic trial of chlorhexidine mouthwash to prevent postoperative pneumonia led by a team of surgeons from the West Midlands.

Is the Clinical Trials Network for me?
The CTN is open to all active clinical investigators across a wide range of perioperative medicine topics. This will include more traditional anaesthetic research domains, as well as those related to the assessment and care of patients before and after surgery. Those of you who are experienced local or principal investigators will find you readily meet the criteria for membership and will easily renew every two years. The minimum commitment is modest but we do want membership to mean something. We are a community of active researchers, and we want each member to put back slightly more than they take out. This will allow us to ensure the network grows consistently, until ultimately we are a world class organisation with a reputation for successful delivery of very high impact clinical trials. One of the criteria we will consider when reviewing a new trial for adoption is the commitment the trial leaders make (or will make) to the CTN.

Summary
The CTN is a group of clinical researchers in which every member plays an active role in our success. Particular value and importance is placed on the roles of local and principal investigator within individual hospitals because without the support and commitment of these individuals, no clinical trial will ever succeed. I hope you will consider joining the network today!

CTN meetings
The first meeting of the CTN will be held on 9 November in central Birmingham. Please see our website for details.

References
1 www.pomctn.org.uk
2 www.rcoa.ac.uk/webcast-catalogue

Potential conflicts of interest
The Perioperative Medicine Clinical Trials Network is funded by the four founding NIAA partners, the Anaesthesia Journal, Association of Anaesthetists of Great Britain & Ireland, the British Journal of Anaesthesia, and the Royal College of Anaesthetists, along with the Rosetrees Trust.

The author has received research grants from Nestle Health Sciences, Medtronic, and Edwards Lifesciences. The author has given lectures and/or performed consultancy work for Nestle Health Sciences, Medtronic, Edwards Lifesciences, and Massimo Inc, and is a member of the associate editorial board of the British Journal of Anaesthesia.
Health Services Research Centre

The RCoA/HSRC Quality Faculty

“This is just what we do...”

Ramani Moonesinghe
Director NIAA Health Services Research Centre, Chair RCoA/HSRC Quality Advisory Group, Health Foundation Improvement Science Fellow

Carolyn Johnston
Deputy Chair, RCoA/HSRC Quality Advisory Group, Founding Cohort, Health Foundation Q Initiative

Sharon Drake
RCoA Director of Clinical Quality and Research, and Deputy Chief Executive

NELA, PQIP, EPOCH, the EL Collaborative, the Q initiative... there is a lot going on around quality measurement and improvement at the moment – and it is fantastic that anaesthetists are at the forefront of delivering the NHS ambition to be a learning, reflective and continuously improving organisation.

We know, however, that while there are pockets of excellence throughout the NHS, and a number of individuals who could be considered Quality Improvement (QI) leaders from our own specialty, we still have some way to go in developing QI capability amongst all anaesthetists and perioperative care teams.

The RCoA and the NIAA Health Services Research Centre are working to bring together all of the exciting developments in QI nationally and locally, and to build capacity and support anaesthetists in the art and science of healthcare quality improvement.

The central core of this work will be the development of a Quality Faculty. Faculty membership will be open to all anaesthetists, both junior and senior, physician and non-physician. Our aim is simple: to make QI ‘just what we do’. This ambition has already been achieved with teaching and training – we all accept and embrace the fact that being a teacher is just part of being a good clinician. All we want to do is adopt the same philosophy in QI. There are lots of opportunities to achieve this through coordination with existing programmes:. Examples of these include the National Emergency Laparotomy Audit, the Perioperative Quality Improvement Programme, the Scottish Patient Safety Programme, regional trainee-led networks, Collaborations for Leadership in Applied Health Research and Care and Academic Health Science Networks, amongst many others, as well as departments devising their own QI strategies based on local priorities. Support for these efforts is already available from anaesthetist-led resources such as PRISM [www.prism-ed.com] and the RCoA Compendium of Audit and QI recipes, and also broader efforts such as the Academy of Medical Royal Colleges “Better Training for Quality Improvement” collaboration, and the Health Foundation/NHS Improvement Q initiative (http://bit.ly/29gSSI)]. The Faculty will bring all of this together to maximise opportunities for shared learning, avoid duplication, and coordinate efforts to further develop us as a specialty.

We can extend the comparison with education and training further to help explain how we hope the Faculty will work. We see Faculty membership as an opportunity for personal and professional development for any of you who want to engage with it. There will be a pyramidal approach to membership and progression (see Figure 1). At entry level, the broad base of the pyramid,
Faculty members will have grasped the nuts and bolts of QI methodology, and have engaged with a QI project themselves – analogous to the training role of a clinical supervisor who provides in situ support to trainees and colleagues from other health professions. Ultimately, our ambition is that all consultants and trainees reach this standard. Next stage up, a smaller number of anaesthetists will have developed the skills and knowledge to be able to supervise and appraise QI projects within their department – a bit like an educational supervisor looks after a few trainees. One stage further up, we hope each department will have at least one QI lead who takes responsibility for co-ordinating all QI efforts and who has undergone personal and professional development to support their leadership role – somewhat like the College Tutor role for education and training. Some departments will already have a Quality Audit and Research Coordinator who has the skills to fulfil this role, others will need support to develop this. Finally, at the top of the pyramid, a few individuals within each school of anaesthesia will have developed their skill-set to be able to lead and mentor regional networks and really drive opportunities for shared learning and collaborative approaches to improvement.

We have given a brief overview of the framework we propose for the Faculty, but are looking to you to help us develop it – both in shaping the plans and in delivering the vision. All Fellows and Members of the RCoA will soon be invited to give their feedback on these plans. We will email you asking you to complete a short electronic survey, and we would be grateful to you for spending a few minutes on this. We will use the responses received to refine our proposals, before launching the Faculty on the RCoA’s 25th Anniversary of being a Royal College next March, as a highlight of the Jubilee year celebrations. Please look out for the survey email and help us to develop these plans – we are looking forward to working with you.
RCoA Perioperative Medicine National Clinical Leads

Chis Snowden
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The purpose of this article is to introduce the two perioperative medicine (POM) national clinical leads, provide some background on the College and on POM developments, and to outline the initial plans of the POM national clinical leads.

In March 2016, two RCoA national clinical leads for perioperative medicine were appointed for three years, subject to an annual review. They have one programmed activity per week each, in order to enable each post-holder to dedicate a minimum of four hours per week to the role. Both leads are consultant anaesthetists and have been at the forefront of promoting aspects of perioperative medicine for many years.

Background
Towards the end of 2013 the Council of the Royal College of Anaesthetists set up a short task & finish group on perioperative medicine. Professor Monty Mythen, a member of the Council, was asked to lead the group with Sharon Drake, Director of Clinical Quality & Research, as the managerial lead.

The remit was to develop a long-term strategy around a vision for perioperative medicine, and to report back to the Council. Within the main task and finish group there were three sub-groups - a leadership group chaired by Prof Mythen, a standards and service design group led by Dr Colin Berry, and a training and education group led by Dr Chris Carey. The groups met between January 2014 and January 2015. The main output from this task and finish group is on the College Perioperative Medicine microsite – www.rcoa.ac.uk/perioperativemedicine and includes:


Dr Chris Snowden, trained in Newcastle upon Tyne and appointed as a Consultant Anaesthetist at the Freeman Hospital in Newcastle upon Tyne in 1997. Since then he has developed several aspects of the perioperative medicine vision both locally and regionally. This includes a preoperative assessment clinic incorporating a large cardiopulmonary exercise testing facility developed over two sites, and a colorectal enhanced recovery program. He is fully research-active in the perioperative area, holding several national grant awards, while continuing to work on a regular clinical commitment to high-risk surgery including transplantation. Chris's interests include preoperative patient preparation for surgery, especially cardiopulmonary exercise testing for patient assessment, and prehabilitation processes.


The leadership group continues to develop the College's perioperative medicine programme.
Perioperative medicine – key messages

- Anaesthesia is central to the delivery of safe and effective perioperative care. Perioperative medicine is a strategy to work with other healthcare professionals to promote this philosophy, whilst maintaining the practice of anaesthesia at its core.

- Patients are at the centre of perioperative medicine and should be empowered to fully participate in their own healthcare choices, making well-informed decisions about all aspects of their care.

- Perioperative medicine describes the practice of patient-centred, multidisciplinary, and integrated medical care of patients, from the moment of contemplation of surgery until full recovery.

- Perioperative medicine improves the short-term safety and long-term effectiveness of surgical treatments by the delivery of multidisciplinary integrated medical care before, during, and after surgery.

- The Royal College of Anaesthetists is committed to leading quality improvement in perioperative medicine across the UK through defined competencies within anaesthetic training, evidence-based national standards, and world-class research.

- Much of the necessary resource and elements of best practice in perioperative medicine already exist; our goal is to see these resources appropriately allocated to maximise patient benefit and to share and develop best practice across the NHS.

Specific duties and responsibilities of the perioperative medicine national clinical leads

Following the development of the RCoA vision, the appointment of the National Clinical Leads was approved with an overall remit to provide clinical leadership for and to assist in the ongoing development of the RCoA perioperative medicine programme. Examples of work which the national leads will be involved in include:

- Dissemination of perioperative medicine information, including speaking on behalf of the College and other bodies at national and local meetings.

- Providing oversight and support to the POM local clinical leads, and encouraging the appointment of a POM local clinical lead in all anaesthetic departments.

- Identifying, through the POM local clinical leads and other sources, specific examples of good clinical practice for the POM microsite.

- Identifying the barriers preventing others from adopting examples of good practice, and the professional support required to overcome these barriers. Additionally, promoting the facilitation of good practice implementation.

- Supporting and integrating other RCoA activity that involves POM, for example, PQIP (Perioperative Quality Improvement Programme), GPAS (Guidelines for the Provision of Anaesthetic Services), ACSA (Anaesthesia Clinical Services Accreditation), SALG (Safe Anaesthesia Liaison Group) and the Quality Working Group.

- Working with existing cross-specialty courses such as CRISP (Care of the Critically Ill Surgical Patient) and POPs (Preoperative Assessment and Optimisation of the Older Surgical Patients) to introduce aspects of POM.

- Using quality improvement methodology to document discrete projects on perioperative medicine.

- Developing business cases and examples of financial savings that can be achieved by implementing or developing aspects of perioperative medicine.

Perioperative medicine national clinical leads: initial plans

- Continue to develop a network of POM local leads in hospitals around the UK, and aim to have 100% local lead coverage in all UK NHS hospitals.

- Survey POM local leads to identify examples of good practice, barriers to adopting examples of good practice, and support required to adopt examples of good practice.

- Use collected cases to develop practical solutions that can be adapted and implemented at local level – not ‘top down’ solutions. We aim to develop a ‘toolkit’, including business cases of possible POM strategies and practices that can be used at local level to develop POM services and pathways.

- Support POM to help them develop perioperative medicine at a local level.

- Appoint a perioperative medicine Clinical Fellow.

- Set a date for the first national perioperative medicine local leads meeting at the College: Tuesday 31 January 2017.

Summary

There is a spectrum of opinion on perioperative medicine amongst members of the College, ranging from enthusiasm to develop it, through uncertainty about what it means and concern about its implications, to actively opposing the concept and the use of its name. The recent RCoA Members’ Survey in 2016, which is currently being analysed, indicates that the number of those opposing the development of POM is small. We need to focus our time on supporting those who are enthusiastic in developing POM, and providing more information and open communication links to those who are uncertain about what POM is about.

We would welcome feedback, questions or requests for more information by email at: perioperativemedicine@rcoa.ac.uk
A view from the high-level isolation unit

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Looking out across London from the 11th floor of the hospital, I watch the sun rising over the iconic landmarks of the capital, and another morning begins. Below me everything is rapidly moving up a gear. People are rushing around purposefully, the traffic is merging into one long river of metal that flows through the city’s arteries and veins. All appears to be running like clockwork and, on the outside at least, this appears to be just another day in the busy metropolis.

I had never dwelt on the surreal nature of hospitals before but, as I turned away from the window to face the patient in front of me, I was struck by the magnitude of the situation: a patient battling for life against a disease usually found far from these shores, where its severity and rapid spread had devastated whole countries and was fast becoming a serious global concern. During the greatest outbreak of this disease in history, Ebola had now reached London.

This was not the first time, however, that the Ebola virus had appeared in the UK. In 1976 a member of staff from the Microbiological Research Establishment at Porton Down suffered a needle-stick injury while handling the Ebola virus and soon succumbed to the then recently-discovered disease. He was transferred to Coppetts Wood Hospital in North London, and placed in their newly designed isolation unit for the duration of his illness. Not only was his recovery hailed as a great success, but the manner in which he was nursed provided a new paradigm in this field and formed the foundation for the high-level isolation unit (HLIU) at the Royal Free Hospital (RFH). This unit forms part of the nation’s defence against viral haemorrhagic fevers (VHFs). It provides expert medical and nursing input for patients unfortunate enough to contract these life-threatening diseases, as well as a safe environment for the staff caring for these contagious patients. The most recent Ebola outbreak resulted in a number of admissions to the RFH HLIU, all of whom were nurses from the UK who contracted the disease while caring for its victims in Sierra Leone.

Looking through thick glass into the purpose-built unit, I can see the plastic tent, now a familiar image from countless newspaper reports, occupying the centre of the isolation room with our patient inside. Despite the gravity of the situation there is an air of calmness about this place. Some members of the team are inside the room with the patient, while others look in from the observation station. I wonder briefly whether any of the Londoners below are looking up to the hospital that looms over Hampstead to spare a thought for what is happening inside.

Time to go in. The design of the unit is such that it is acceptable to walk around the ‘clean’ areas dressed in regular clothes, but to access the isolation room, one must first change into surgical scrubs before passing through a double set of doors to gain entry. It is quiet inside. At least two nurses are present in the room 24 hours a day, providing expert care for the patient’s every need. The tent, originally designed back in the 1970s by Philip Trexler, surrounds a standard hospital bed, with a small space on one side to allow the patient to stand up, if they are well enough. Five ‘half-suits’ penetrate the walls of the tent, two either side and one at the head end, to allow clinical staff to access the patient while protecting them from direct contact. The beauty of the Trexler tent is that, because the suits form part of the tent wall, there is low risk of contaminating oneself when attending the patient compared to standard personal protective equipment (PPE). With PPE, there is potential for contamination of the skin and mucous membranes during doffing, and this may have contributed to numerous healthcare workers becoming infected during the lengthy battle against Ebola in West Africa. The Trexler tent also requires significantly less training for staff than traditional PPE, although it does bring with it a number of unique challenges; not least of which is the delivery of critical care and organ support. The mere act of getting into the half-suit requires some effort, bending and contorting yourself to simultaneously extend your arms into the sleeves and your body through the orifice to gain access into the tent. Once within the suit you are literally inside the tent, leaning...
somewhat awkwardly over the patient within, suddenly finding yourself sharing the strange world in which they have been confined.

When a patient is diagnosed with a VHF in the UK, or is brought back from abroad after contracting the disease, there is a well-rehearsed drill to get them to the RFH as quickly and as safely as possible. The Royal Air Force play a crucial role in this process, collecting the patient in an air transport isolator (ATI), and accompanying them in a military aircraft to a suitable landing site. The RAF team, accompanied by one of the RFH doctors, cares for the patient during this journey, which, for two of the recent admissions, was directly from Sierra Leone. Deterioration in a patient’s condition during transfer can be a very challenging scenario due to many impediments encountered while attempting to treat an unstable patient in an ATI. Once on land, the patient travels to the RFH in a modified ambulance large enough to accommodate the ATI. The final part of the process is entry into the hospital, again well-practised, under the protection of a strict cordon, with rapid access to the HLIU on the 11th floor. Once in the isolation room, a team must facilitate the interlocking of the ATI with the Trexler tent and the transfer of the patient from one to the other. From this point on, the sealed Trexler tent will be home for that patient until they are deemed to be no longer viraemic. It is hard to imagine how claustrophobic and cut off from the world one must feel while confined in such an environment for weeks at a time, but its effectiveness in preventing spread of this deadly disease has been demonstrated time and time again. It remains the nursing method of choice for all patients diagnosed with a VHF in the UK.

Back in the isolation room, we begin preparations to insert a central venous catheter, a key component of our strategy with infected patients, as it allows us to draw blood safely for laboratory analysis and to aggressively replace intravascular volume and electrolytes. Despite Ebola being classified as a VHF, the predominant symptoms in this particular outbreak were diarrhoea and vomiting, the magnitude of which has few other clinical comparisons. It can lead to patients being in several litres of negative fluid balance each day if not corrected. As the disease progresses, levels of potassium, calcium, phosphate and magnesium fall precipitously. Together these represent the components of the disease most likely to lead to death. Meticulous fluid management plays a central role in the management of patients with Ebola, and involves navigating a narrow and hazardous path that resuscitates hypovolaemia and prevents acute kidney injury, without incurring fluid overload leading to respiratory failure. Our ability to effectively treat rapid and severe electrolyte derangement in these patients is only possible because of the purpose-built containment level 3+ laboratory within the HLIU and the dedicated team that operate it round the clock. A limited but essential profile of investigations can be safely processed from this laboratory in order to guide therapy.

When carrying out procedures in the HLIU, the ethos of the unit constantly echoes in one’s mind - safety first. Although this is clearly standard advice for all clinical situations, when dealing with a disease with such devastating repercussions (over 11,000 deaths reported by the WHO in the current outbreak, of which more than 500 were healthcare workers), safety of the staff caring for these patients must be an absolute priority. Infection of a member of staff, or a local outbreak of the virus, is an unthinkable scenario. Rigorous procedural guidelines, the design of the unit, training and experience - all contribute towards safeguarding, but in addition, each treatment strategy or procedure is individually assessed to ensure that at no point is any member of staff placed at risk from their actions. Central venous catheterisation is no exception to this, and can present a significant challenge in the agitated, isolated patient. Like every procedure in this situation, it is carefully planned and carried out in the presence of skilled assistants who, among other things, provide a second set of eyes to guard contaminated sharps. Doing anything in the Trexler tent takes a great deal of time, but that time is considered a vital part of the process.

Perhaps the greatest surprise to many healthcare workers in West Africa, and those observing from afar, was the much lower than expected incidence of haemorrhagic sequelae. Ebola virus disease is much feared - primarily due to the catastrophic bleeding that is
usually associated with it, yet only 18% of patients exhibited unexplained bleeding in West Africa. An ominous sign of early coagulopathy is bleeding from the insertion site of intravenous catheters. During the treatment of patients at the RFH, we decided to implement thromboelastography (TEG-5000 analyser, Haemonetics Corporation, Braintree, Massachusetts) in the HLIU laboratory. This provided us with a better understanding of clot formation in the patients, and helped to guide therapy. An unexpected finding was the development of a post-illness hypercoagulable state in two of the patients we treated.

On leaving the isolation room, you pass, through a different set of doors from those through which you entered, into an area where you must shower before proceeding. Scrubs are removed to be autoclaved, and if you chose to wear your own underwear, that’s the last time you’re likely to see it again. Once clean you eventually appear back where you began, in the corridor that leads to the patient observation area. Waste processing is a crucial component in the design of the RFH HLIU. Huge volumes of clinical waste are generated during the care of a patient infected with Ebola virus, all of which needs to be rendered safe in the unit’s built-in autoclaves. This element of management can be one of the most challenging for centres not specifically designed for this purpose.

Treating such complicated patients also demands a vast amount of work away from the frontline clinical area. The core team meets twice a day for a detailed situation report and to plan care for the next 12 hours. The quality of the integrated multi-disciplinary interaction demonstrated during these meetings was the highest I have had the privilege to experience in my career to date. It was a shining example of how individuals from far-reaching disciplines could come together and solve complex problems, in a highly unusual clinical scenario in which there was very little evidence to guide us. Decisions regarding the use of experimental therapies were particularly testing. During this outbreak a number of therapies were available to us: convalescent plasma from survivors, monoclonal antibodies and novel antiviral compounds, all with potential to improve outcomes, but with limited evidence yet available to support their use. The ethical conundrum created by this situation was not treated lightly. Expertise was sought from other groups around the world, to evaluate the risks and benefits of these compounds. Then followed the challenge of actually obtaining the medications, gaining the national and local approval to use them and, of the greatest importance, discussing the known facts with the patients who were to receive them. This previously untrodden path became familiar to the HLIU team each time a new strategy had to be considered.

Leaving the hospital at the end of the day, there would often be a news van parked outside with its huge satellite dish pointing into the night sky. Sometimes a reporter would be waiting, poised under an umbrella for the evening news team to cut to them live outside the hospital responsible for treating the most discussed patient in the country, and for protecting the rest of its citizens from the deadly virus now contained within its walls. And before bedtime, feet up at home, the peculiarity of these difficult days was often concluded by listening to a brief update on the patient’s condition through press releases on the late night radio news.

So what have we learnt in the West about a disease that devastated three African countries for over a year? The collective experience of the European and North American centres that treated repatriated and locally diagnosed patients was recently published. The take-home message is that in an environment not limited by resources, the mortality rate from this disease can be reduced to less than 20%, a stark comparison to rates of 50–70% reported from Africa during the epidemic. This was primarily achieved through the ability to maintain hydration intravenously, correct electrolyte abnormalities, deliver adequate nutrition, and provide organ support for respiratory and renal failure. Whilst experimental therapies were given to 85% of the 27 patients treated in Western medical facilities, their efficacy remains unknown. These compelling data lead one to think about how best to tackle the next outbreak of a VHF in a resource-poor setting. Should the West be helping to provide critical care facilities in these countries? Is it possible? Is it affordable? Would it be so effective?

None of what was achieved at the RFH in recent times would have been possible without the collective input of the entire hospital. The countless staff that worked directly with the infected patients, the supporting services that kept the facility running safely, 24 hours a day; and everyone else in the hospital who quietly took up the slack in the absence of their colleagues committed to the HLIU during this period. This unique example of how a team worked together in an adverse situation, fighting what was thought to be an unwinnable battle, will hopefully provide inspiration to the next generation of healthcare professionals in the National Health Service.

References
FOAMed* – the future of postgraduate medical education?

(* - ‘Free, Open Access, Medical education’)

The FOAM Film Festival Organising Committee

‘If you want to know how we practised medicine five years ago, read a textbook. If you want to know how we practised medicine two years ago, read a journal. If you want to know how we practise medicine now, go to a conference. If you want to know how we will practise medicine in the future, listen in the hallways and use FOAM’.

The problem
We are living in a time of austerity. The medical needs of our aging population are growing faster than the healthcare budget. With the rapid pace of change in medical science and the high demand for delivery of up-to-date evidence-based medicine, the importance of continuing professional development (CPD) and medical education is greater than ever.

Conversely, education and the training of healthcare professionals are not always protected from the drive to improve efficiency. Time in the working week that was previously set aside for CPD is being lost to delivering direct clinical care, making quality training time increasingly precious. In short, we need to start learning more, faster.

Traditionally, medical education came from textbooks, journals and lectures. However, there is increasing evidence that these methods may not be the only effective way of learning. In 2008, two Colorado schoolteachers, Jonathan Bergmann and Aaron Sams, stumbled upon a novel idea. Faced with a problem of finding time to re-teach lessons to absent students. They began to record, annotate and post their lessons online, so those absent students could catch up. To their surprise they also noticed that their other students began using these videos to reinforce what they had learnt in class.

Taking this further, they encouraged all their students to initially study online material at home, learning important facts and technical details. Then, classroom time was used to check understanding, work through problems, and encourage deeper thinking. Trials have demonstrated that this technique compares very favourably with more traditional teaching methods.

The ‘flipped classroom’ method is easily applied to learning in theatre. The learning goals are identified in advance; the trainee does some initial learning at home, acquiring essential background knowledge. During the training session itself, the trainee is able to engage in a discussion of this topic with the trainer, clarifying uncertainties and evaluating evidence to acquire a deeper understanding of the topic. This discussion, critical evaluation of evidence, and encouragement of deeper thinking is at the heart of a new movement in medical education, and that is FOAM.

What is FOAM?
FOAM is a collection of online resources or media, produced by individuals or by groups, that may take a variety of forms including podcasts, blogs, tweets, Google hang-outs, online videos, text documents, photographs, drawings, info-graphics – just about anything. FOAM is not scientific research – it is simply a way of collating, disseminating and discussing the growing wealth of online medical resources that are free, open and easy to access. Recently published journal articles or guidelines are some of the most obvious sources for discussion, but it is by no means limited to this.

The unifying characteristic of FOAM resources is that they are freely accessible to all, willingly shared and modified for use in different settings. Sharing of ideas and collaboration between individuals and groups is encouraged. This distributive model of education encourages peer-to-peer learning, at a time and place to suit the learner. These novel education methods have the potential to transform postgraduate medical education and revolutionise how CPD and lifelong learning is achieved.
One of the most important features of FOAM, that sets it apart, is its ability to distil a topic into something manageable and understandable. A focused literature search of any topic in the anaesthetic curriculum will produce thousands, if not hundreds of thousands, of results. It is easy to get overwhelmed and lost with all of this information, and it can be almost impossible to pick out the important and significant articles from the rest.

With FOAM, much of this work is already done – an up-to-date, well-written blog by an expert is likely to cite landmark research papers, discuss controversies, and highlight further research questions. This is not to discourage us from reading the original research papers ourselves, but to add value and encourage thought when we do read the paper. Comments left by others can be equally educational, perhaps offering a different perspective, a new argument, or interesting criticism of the article.

**Blazing a trail**

Emergency medicine and critical care are leading the way with FOAM. Indeed, the Royal College of Emergency Medicine (RCEM) has its own FOAM network, created in addition to the RCEM’s more conventional online learning environment. This website is “not trying to replace traditional education but instead be a chatty and informal commentary to engage everyone in the fascinating and engaging nature of medicine.”

Other FOAM resources include www.thebottomline.org.uk, probably the best online educational resource for searching clinical imaging), Critical Care Horizons and The Bottom Line (which lead the way in succinct critical care opinion pieces, commentaries and review articles), and Cambridge Critical Care (which encourages users to use the ‘flipped classroom’ approach to learning).

The online FOAM collection is already vast and ever-growing, with new resources being added every day. Lifeinthefastlane.com, for example, which includes a collection of blogs, podcasts, ECG library and other resources, gets more than 30,000 hits daily. Social Media and Critical Care held its first conference in Sydney in 2013 and, despite no formal backing from any society, university or college, attracted 700 delegates. The 2016 conference in Dublin sold out with a cap of 2000 delegates! FOAM is now impossible to ignore.

**The issues with FOAM**

There are issues with FOAM we have to think about. The direction we are heading is towards a model where all medical education in some form will be delivered by various media platforms that demand unrestricted sharing, and where peer review happens when journal papers are published online, rather than anonymously before publication. This raises potentially significant governance and quality assurance problems. How do you know on what platforms and what information your trainees are learning? How can you be sure whether or not someone is actually an expert? Can you be sure whether there are conflicts of interests, or whether resources have been funded directly or indirectly by the pharmaceutical or medical devices industries? Finally, where does this leave our previous regulatory organisations within postgraduate medical education, when you potentially find and generate training material yourself and from your peers?

**Our experience**

Enthused by the possibilities of FOAM and aware of its pitfalls, a group of anaesthetics trainees in East Anglia have got together to create a novel learning resource - inspirational, educational and peer-reviewed films, archived and freely available. We have all worked with inspirational colleagues who are fantastic teachers. These people may have a gift for developing an instant rapport with their patients, a passionate encyclopaedic knowledge of their subject, or particular expertise in a practical skill. Whatever these magical qualities are, learning from these individuals leaves us with a feeling of energy and enthusiasm and a desire to find out more, and we felt that these brilliant teaching moments were too good not to be shared.

Last year, we invited colleagues and peers in our region to make short, five to eight minute, educational videos. Through an advertising campaign, marketing video, social media presence and a website, a number of colleagues produced videos for the inaugural competition, with a prize for the winning film presented at our annual regional meeting. Topics included, among others, rectus sheath blocks, management of bronchospasm under general anaesthesia, and ROTEM interpretation.

It’s not difficult to produce a film. You are never far away from a phone with video capability, and no additional high-tech lighting or sound systems are needed (though clearly participant consent, and avoiding breaches of patient confidentiality are essential). We are running the film competition again this year, and we invite you to submit your own films. In doing so, you will be participating in the wonderful world of FOAM, and could even win a prize!

**The future**

FOAM is changing the face of how we think about medical education, training and CPD. FOAM re defines what medical education is, how we access it, how we disseminate it, and has come at a time when there is a clear need to find ways of making better use of the time we have for learning. We have little option but to embrace the brave new world of FOAM, maximising the opportunities that it offers, and finding solutions to the problems, changing medical education forever, for the better!
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The role of the nurse within perioperative medicine

Emma McCone
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The launch of the RCoA perioperative vision is an incredibly inspiring look at how the next five years will help shape patient pathways in the elective surgical world. NHS services are facing challenging times as the prevalence of patient frailty, chronic diseases and poor lifestyle choices are escalating, and patients’ choice for surgical intervention becomes more accessible. Coupled with the technological advances in surgical innovations and techniques, the NHS is now performing 10 million operations in the UK each year (RCoA, 2015).

Healthcare professionals in both primary and secondary care are having to form stronger partnerships to allow for more timely interventions, and the government’s implementation of target times means that the surgical pathway from GP referral to treatment has never been so scrutinised.

It is predicted that diabetes will affect 5 million people by 2025 (NHS Choices), and guidance published in 2015 by NICE indicates that over half of the adult population are now classified as obese, which in turn gives rise to other medical co-morbidities. Of course, lifestyle choice has its part to play in these figures, with more and more people increasing alcohol intake (Alcohol Concern estimated in 2015 that more than 9 million people in the UK drink more than the recommended amount), making poor diet choices and suffering from smoking-related diseases, all of which are becoming a burden on our NHS services. These patients will still need and want surgery, although the options available to them will vary and be limited according to their individual circumstances. Whatever the outcome decided upon, and often before the decision is made, it’s clear that the impact of patients’ overall health on the successful outcome of surgery is both poorly advocated and misunderstood, sometimes by the healthcare professionals, but mostly by the patients themselves. Lifestyle changes like smoking cessation and exercise can dramatically reduce postoperative risks, yet patients don’t have routine lifestyle coaching in the weeks before an operation. Despite advances in the preoperative pathways of care, even though these are still often inadequately resourced, there needs to be a stronger focus on the postoperative outcomes that are directly linked to co-morbidity and mortality. It is this focus that supports the perioperative vision by putting patients back at the heart of what we do, giving them the autonomy to do it and educating and training them to change their own perception on health at the earliest opportunity.

The traditional preoperative assessment method would be the surgical model of ‘clerking’ the patient in a limited time before the proposed operation. Problems identified could potentially result in cancellation, postponement, or referral to another clinician to seek an opinion to see if the long-awaited operation was even suitable. It was a lengthy process, which would only disappoint the patient who had waited months to be ‘fixed’. In addition, the patient who ‘could have been worked up a bit better’ would present to the anaesthetist on the day scheduled for surgery, and he/she would make the decision to proceed or not. It would also be fair to say that some anaesthetists would admit to not reaching the ideal preoperative state but accepting that it was ‘good enough’!

The introduction of pre-assessment clinics was welcomed and promoted in the anaesthetic world, and for those trusts who have embraced them, they have brought a more streamlined service of risk assessment, targeted investigations and patient education. For the first time, surgeons have a point of referral for assessment of fitness for surgery without having to add patients to a waiting list. More importantly, we are applying newer methods of patient involvement including behavioural interventions, shared decision making and optimisation in the weeks before the operation takes place. Targeting patients in this way helps formulate a much better care pathway of patient autonomy, surgical intervention and anaesthetically safer approaches for a well-informed team, with the patient at the heart of everything we do.
This journey is often initiated by the primary care team, however, it is sometimes an underlying abnormality such as anaemia that necessitates a surgical referral for a patient already in the hospital system. So where does the intervention of being prehabilitated start? And which services are geared up to initiate the processes? More importantly, which resource in our already stretched NHS services do we utilise to help our patients have the best postoperative outcomes and the shortest length of stay, and recover in the quickest time possible?

You guessed it - the nurses!
Specialist anaesthetic preoperative assessment nurses have been shown to be safe and effective at preoperative screening, and should be an integral part of the team.1

Nursing has undergone huge changes in the last ten years. The pressures on all primary and secondary care NHS services have meant that practitioners have had to change their routine practice to become experts in different fields, learn new technologies and techniques, and take part in the significantly growing world of research. The hierarchical structure has become “flatter”, and doctors, nurses, and all other members of surgical and medical teams are now working collaboratively to deliver high-quality care in pressured situations.

A preoperative assessment service is now available in most NHS and private hospitals. Whilst it is pivotal to the elective surgical pathway, many trusts underestimate the complexity of the planning required, not just from a staffing resource perspective, but also its physical location, the adequacy of the space available (currently, most of us assess from an unused treatment room or cupboard!), and the creation of the protocols and documentation needed to implement it successfully. The so called ‘ob and swab’ nurse is still a popular perception amongst our colleagues - a nurse who sits in outpatients ticking a health questionnaire and getting the patients ‘fit’ for surgery in the quickest time possible using limited resources. Whilst there has to be a certain air of urgency for some operations where the clock is ticking from GP referral to treatment, some business managers have understandably labelled our patients as “missed targets”, failures or fines. That pressure alone can make the decision-making process for our preoperative assessment teams one that is already brushed with a negative vibe. Even our patients, some of whom are living with multiple co-morbidities and poor lifestyle are coming into the pre-assessment clinics with a perception that surgery will be, and can be, the only outcome.

So what are our challenges?
Anaesthetists are undoubtedly the best resource to lead the pre-assessment nursing teams. Consultants with an interest in perioperative medicine are best situated, with set sessions in the pre-assessment clinic to support and guide the nursing staff into the best practice of risk assessment before surgical intervention, or helping the surgeon decide on alternative treatments. But, in order to enable this, the right nurses need to be employed for specialist tasks, trained in a variety of clinical skills (even cardiopulmonary exercise testing should be a nurse/ODP led service), educated about behaviour change and health promotion, while working within easily useable guidelines such as those of NICE.

So how is this achieved?
Pre-assessment nursing leaders need clear vision and values of what perioperative medicine is. Employing a nurse without a good grasp of the perioperative pathway to lead a team of pre-assessment nurses will only blur the lines of productivity and patient throughput against the gold standard assessment they strive to achieve. Perioperative teams waited 13 years for NICE guidance2 to be released with long-awaited indicators of when and on which patients to conduct tests. Unfortunately, words like ‘consider’ in the documentation mean the guidelines are ambiguous and rely on the nurses to make clinical judgements that, if wrong, may result in a cancelled operation. Nurses like to work within structured protocols that are evidence-based and that have been drawn up by a knowledgeable multidisciplinary team. Blurring of these protocols only gives rise to phrases like ‘Was it me?’ coupled with an air of self-loathing for being ‘the one’ responsible for the patient not getting their long-awaited operation. Our nursing leaders need a well-defined concept of how to implement processes
that nursing teams can follow with ease and confidence. Supported, guided and trained by our perioperative clinicians, our pre-assessment clinic services should follow a model that allows most patients to go through nurse-led assessment. Even for complex tertiary referral centres, with the right protocol, the right staff and the right processes, patients should follow a very streamlined direction of care to allow for the safest journey into the operating theatre. Risk should be minimised with the appropriate, targeted tests and clinical history skills, and referrals made to the perioperative clinicians only for those patients at high risk (10-15%). Key business drivers such as Day of Surgery Arrival (DOSA), cost effectiveness of processes, reduction in on-the-day cancellations, and CQUIN should all be well audited, and are proven to drive forward successful preoperative clinics.

But how do we join up the pre-assessment pathway to become part of the full perioperative vision which carries on till well after surgical intervention?

Nursing in perioperative medicine has always been focused around pre-assessment, surgery, theatre, recovery and the ward-stay. With more and more nurses taking a real interest in specialist roles, and pioneering new nurse-led services, we have to be able to access an instrumental knowledge-base where clinical expertise can be utilised into the perioperative medicine pathway. The key to this success is to map the patient’s journey, identify the key nurses involved in it, and allow them to work together to formulate a plan that doesn’t make unrealistic demands on their time, but which is effective in benefiting the patient’s journey.

Pain nurses, enhanced-recovery nurses and outreach nurses can all formulate part of the patient’s surgical plan from admission to discharge, and liaise with the primary care teams well after discharge. Coordinating their care in this way not only helps to avoid re-admission to hospital, but also gives patients a responsibility for maintaining their own health and taking an active role in their recovery to normal health, by getting better, healthier and fitter than they were before.

There is lots to consider in the RCoA five-year plan, and while the lead clinicians move around the UK to identify areas of excellence in practice, and to set strategic plans for reaching the goals for better perioperative services, we mustn’t forget that the people who will actually make it work are without doubt the nurses. It can’t be done without them and collaborative working must begin now.

It’s not just ‘obs and swabs’ – the perioperative nurses can rest assured of that!

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Peer coaching and mentoring for trainees at Royal Cornwall Hospitals Trust

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Being a trainee in today’s NHS is a challenging business. With ever-increasing demand, new technologies, healthcare settings being busier than ever, and on-going uncertainty regarding working conditions both now and in the future, trainees have little time to move outside their immediate pressures to think about where they want to go, how they want to be and what they want to achieve.

There is increasing recognition that trainee welfare needs confronting and that it is vitally important to develop skills such as resilience, stress management, goal setting and task prioritisation alongside clinical work. We believe one solution to this problem lies within coaching and mentoring.

Coaching is a powerful learning and development process, enabling people to develop their potential and improve their performance. It is a partnership between two people (‘coach’ and ‘coachee’) who work together on subject matter brought to the conversation by the coachee, to improve their work or life, and to find new and creative ways of doing and thinking about and feeling about things. This is a confidential and non-judgmental relationship based upon mutual trust and respect. Each adult is an equal in the conversation. The coach holds the belief that the coachee has the answer and solution to any problems or dilemmas, i.e. the coachee is the expert on their own life and workplace.

By a process of inquiry, involvement and attunement, the coach gets on the coachee’s wavelength, understands the situation from the coachee’s perspective and aims to improve confidence and focus, increase goal attainment, develop new insights and self-awareness and increase motivation in the coachee, facilitating the coachee’s development towards their own goals.

Coaching within the NHS is normally limited to very high flyers e.g. board members, top leaders, or is used as a remedial tool e.g. deanery trainees who are not achieving a standard. It is very rarely available for other staff. Restriction in the use of coaching is due to limited resources, either in terms of money or skills, and has led to some stigma being associated with coaching and mentoring, which we feel is not deserved. We are unusual in Cornwall in that we offer it to a number of people in everyday roles in an effort to achieve a cultural change for the better.

At the Royal Cornwall Hospitals Trust (RCHT) we have developed a programme to teach trainees basic coaching skills in order that they can offer each other peer support. Every 4-6 weeks a self-selected group of trainees meet to learn coaching techniques and to spend an hour or so acting as coach and coachee to each other, under the supervision of a trained Executive Coach. This coach offers advice and support at each session and quarterly a Coach Supervisor attends to develop and support the group further. As the trainees do not take a formal course and are not
examined or qualified, they cannot call themselves coaches at the end of it, but that is not the aim of the programme. What we achieve is to expose them to new skills that enable them to support and encourage each other, improve the way they communicate and structure their thinking, and begin a journey to a different culture and climate. This process is not only a very therapeutic interaction for all involved, but also represents the first steps on the way to being excellent teachers, trainers, mentors and leaders of the future.

**Structured conversations**
The content of conversations is strictly confidential, and remains between coach and coachee. The process of the coaching may be discussed –what went well, did not go so well – in order to develop skills and abilities further.

The structure used is based on Sir John Whitmore’s GROW model. The coachee brings a topic or issue to discuss. From this the coach will enquire what the coachees ‘Goals’ are, how they wish to use the time, and what they want to get out of the time. The coach will then help the coachee explore the ‘Reality’ of their situation. This is a great section for those interesting and challenging questions that probe deeply, develop insight and ‘switch on light-bulbs’.

From the reality, the coach will move the conversation on to ‘Options’ – what choices are there? And what else and who else and so on? This can be extremely creative and satisfying as the coach will encourage all options not just the one or two at the front of thinking. In ‘Will’/ ‘Way-forward’/’Wrap up for the session’, the coach will then help the coachee focus on their take-away messages, actions for the future, time-scale and commitment to these actions. This leaves the choices and responsibility with the coachee, empowering them to take charge of the next phase of their life or career.

**Governance**
The programme for trainees is supported by the RCHT Coaching and Mentoring.

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**KEY COMPETENCIES FOR COACHES**

- Active listening
- Open questioning
- Comfortable with silence
- Understanding the coachee
- Managing the conversation – using a structure, probing and encouraging the trainee, using positive psychology, reframing negative to positive
- Managing the Space – creating an open and honest and safe space for the coachee to which they can bring their topic
- Being non-judgmental
- Being non-directive (avoiding ‘solution’ mode) – the Coach holds the belief that the coachee has the answer and works to bring that out
- Observation and use of body language, tone and flow of speech
- Reframing negative thinking habits
- Managing the process – using the time well, helping the coachee explore their topic fully, encourage the coachee with outcomes and actions, determining commitment and when they will enact these outcomes.
Programme, which has excellent governance procedures. All coaches and mentors should work within an ethical framework and we have adopted that of our region, NHS SW Leadership. The European Coaching and Mentoring Council codes of conduct. \(^2\) Supervision (education, support and standards) is provided in-house by a trained Coach Supervisor. This enables continued development of the coaches and mentors at RCHT, and ongoing improvement of the Programme. Educational resources are freely available to trainees from the library, shared resource folders and at sessions.

Feedback is very important for coaches to continually grow and develop themselves and improve the programme, and so feedback is collected from the trainees within the programme. Feedback from those outside the programme is not formally collected, but where offered it is collated also.

Peer Coaching and Mentoring at RCHT is in its early stages, but is growing and developing and having significant impact already. We have already expanded from anaesthetic trainees alone to multidisciplinary sessions involving trainees from other specialties, with excellent feedback from all. We would heartily recommend coaching to any NHS staff who can access this, and would strongly encourage other hospitals to consider establishing similar peer-to-peer coaching and mentoring programmes in order to develop a more positive and goal-achieving culture within their departments, and to improve the well-being of their trainees.

References
2. European Mentoring Coaching Council [www.emccouncil.org]

Comments
“Good intro session, I will try to put my solutions into place before the next session. More time for coaching”

“Looking forwards to next session”

“Lovely friendly atmosphere. Non-Threatening. Enjoyed it and thought it worthwhile”

“Really interesting - new experience. Helpful - immediately useful and informative”

“Great to have a broad session and an approach to dealing with a whole life’s worth of topics/goals”

“Good to recap, interesting to hear others perspectives and their through the supervision process – something I’d not formally been through. Helped me to acknowledge how I’ve changed my thought processes and developed my communication skills in real life over the last few months, not only within the actual coaching sessions themselves.”
POET(ry) at Duke University Medical Centre, USA

Thomas Hopkins, Maria Jimenez, Timothy E. Miller, Solomon Aronson
Duke University Medical Center, USA

It is becoming increasingly clear that the opportunity for the greatest health-value impact may lie within the management of the most complex episodes of care for the sickest patients.\(^1,2\) In this patient cohort, early adoption of multidisciplinary specialty-driven, best-practice care design offers the greatest promise to improve value when considered within the lens of population health management. By 2020, it is predicted that approximately 50% of adults in the US will have one chronic disease, and 25% are expected to have multiple chronic diseases, with an estimated 19% of the US gross domestic product being devoted to healthcare.\(^3\)

Additionally, increasing burdens on the health system are expected from an aging population - the US population aged over 65 years is projected to be 55 million by 2020 and 72 million by 2030.\(^4\) Surgical care in particular, which currently accounts for half of hospital admission expenses, is expected to increase as the population continues to age. At present, patients who present for acute care related to surgery are among the 3-5% of high-risk patients that consume nearly 50% of annual healthcare expenditures. Moreover the average cost of a surgical complication is reported to be approximately $12,000 per episode.\(^5\) Thus perioperative medicine in particular is critical to the development of a sustainable “population health” strategy.

The POET process
The implementation of Enhanced Recovery Protocols (ERPs) at Duke led the way to recognition of the broader opportunity to provide optimal perioperative care. Following successes with enhanced recovery, and with the aim of developing a comprehensive perioperative best-practice care redesign team, POET (the PeriOperative Enhancement Team) was launched at Duke in 2013. The principles of POET are to enhance the value of perioperative care through a rigorous care re-engineering process. The collective competencies of a team bring together strategy, operations, tactics, finance, workflow design and planning, project management, electronic health record (EHR) and integration, as well as data development and tracking. Skills sets are brought together to challenge old ways of doing things and to redesign new clinical care processes. Once the clinical outcome improvement and the financial analysis are judged to be convincing, multidisciplinary stakeholders are engaged to help redesign workstreams with guidance from clinical leads and with a project manager to facilitate the proposed operational changes. At the same time, clinical metrics are developed and informatics resources are deployed to enable review of key performance indicators and facilitate continuous performance improvement. The POET process includes a clinical informaticist to advise on how to best use health information technology to facilitate efficient implementation of the targeted initiative. Early alignment with project management enables workflow to be effectively tied to the EHR. Furthermore, POET focuses on leveraging existing data stores to support this process and to build new discrete data elements when necessary. These data are then used to build the architecture required to support robust longitudinal analyses for a given project. Following implementation, we re-evaluate workflows to improve efficiency, patient safety, patient satisfaction, quality of care and financial effectiveness.

POET Preoperative
Among the opportunities to improve perioperative population health, it is clear that focusing efforts on preoperative assessment to better address modifiable clinical conditions is important. Preoperative evaluation processes should, ideally, collate information, recognise risk, address risk, communicate risk, and reduce risk. In addition, patient-centred involvement, including patient
education and patient engagement with aligned expectations, need to be core to the process. That said, POET sets out to establish a perioperative medicine coordination team with a focus on preoperative screening and subsequent care optimisation for modifiable risk factors. The PREOPs (Preoperative Risk Evaluation and OPtimisation) clinic can ideally also perform counselling for diet modification and smoking cessation; screening for preventive health metrics, including flu and pneumococcal vaccination compliance; adherence to best-practice perioperative laboratory testing standards as well as candidacy for other optimisation strategies (e.g. identification of patient need for alignment to ERPs, perioperative blood management protocols (CLOT - Coagulation and lysis oversight team), perioperative device management protocols (PACED – perioperative cardiac electrophysiology devices), perioperative pain management protocols (PCMC - Perioperative Chronic Pain Management Centre), handoff transition of care protocols and postoperative follow-up).

The POET-identified preoperative modifiable risk factors, together with optimisation initiatives, are listed below:

- Anaemia - preoperative anaemia clinic.
- Poor glycaemic control - preoperative diabetes clinic.
- Malnourishment/obesity –preoperative nutrition optimisation clinic.
- Complex pain - perioperative chronic pain management centre.
- Poor exercise tolerance – perioperative functional readiness and prehabilitation clinic.
- Elderly, complex medical, frail – perioperative optimisation senior health clinic.

The first POET initiative (presented in detail as an example for all subsequent initiatives) was the preoperative anaemia clinic. The objective was to optimise the patient’s preoperative red-blood-cell mass, and thereby avoid the critical intraoperative/postoperative transfusion threshold decision altogether.

Issues addressed by POET in the process of creating the preoperative anaemia clinic included:

- Comparative research of our institution’s transfusion rate.
- Identification of a pilot population (e.g. patients needing joint-replacement).
- Institutional review of patients that had total joint replacement to determine pre-procedure haemoglobin (hgb) thresholds associated with transfusion.
- Determination of a procedure-specific preoperative hemoglobin target for transfusion avoidance.
- Determination of clinic volume projections for workflow and resource analysis.
- Financial modelling of the anaemia clinic’s impact.
- Development of a comprehensive treatment and diagnostic workflow model.
- Clinic workflow design.
- A point-of-care device screening tool to allow for instantaneous results and referral.
- Staff planning requirements (e.g. nurse managers, pre-anesthesia testing (PAT) clinic, centre for blood conservation staff, infusion centre).
- Physical space arrangement planning.
- Integration of laboratory ordering into an electronic medical record (EMR) order set.
- Integration of scheduling and care team communication into the EMR.
- Patient education needs.
- Institutional introduction of the preoperative anaemia management program.
- Continuous institutional communication of program on-going status/success.

The POET goal was to maximise efficiency and effectiveness of preoperative identification of patients at high risk, and to bring clarity of diagnosis and treatment (optimisation) of the modifiable risk factor (anaemia) prior to surgery. In addition, POET focused on maximising patient convenience and staff satisfaction, while minimising staff workflow disruption, communication errors, patient loss to follow-up, and cost. Since the launching of our preoperative anaemia clinic – which has now expanded to several surgical services, over 50% of patients are screened in our hip and knee clinics for anaemia, with 15% of those patients referred to the preoperative anaemia clinic for pre-surgical treatment. To date there is less than 2% transfusions among the patients who have completed treatment. In addition, similar data exists among patients screened and referred for treatment who are seen in our perinatal clinic.

Changing the paradigm

Whilst each healthcare system will reflect a unique mixture of roles among physician, nurse, and physician extender specialties, it was our goal to have the Duke process become a national model for risk evaluation, preoperative care optimisation and resource stratification using evidence-based interventions to improve patient outcomes and enhance the value of care. The current standard of care in the US employs a PAT clinic just prior to an established surgical date. Once a patient is declared “surgical”, the PAT clinic (Figure 1) enables clerical requirements to be met; however, there is minimal opportunity to make any impact on medical management. Such gaps in the “PAT only” process for surgical readiness must be addressed in an outcomes accountable healthcare system.

Ideally, a surgical care plan should begin when a patient is first identified for surgery, and should include coordination between relevant specialties and support services so that essential medical data and information for the patient are
appropriately shared and continue seamlessly until the patient is fully recovered from surgery. The surgical readiness processes should include a comprehensive perioperative medicine coordination process, whereby a patient is directed to a PREOp clinic after being declared “surgical”.

Hence transformation of pre-surgery processes needs to evolve to include:

- **Improved access to health care services for more complex patients** (Figure 2).
- **Tracking and coordinating pathways for preoperative optimisation** (a useful analogue from a different discipline would be air traffic control).
- **Patient stratification according to surgery type and complexity and patient risk score**.
- **Disposition planning facilitated by risk stratification score and surgery description**.
- **Predictive models for postoperative resource planning to predict bed, staffing, and other needs**.
- **Standards for preventive healthcare of patients undergoing perioperative care** (e.g., nutrition management, smoking cessation coaching, chronic disease management).
- **Advancing discussions for goals of postoperative care, with patient and family engagement**.

**POET Intraoperative**

POET remains engaged with implementation of ERP protocols, and has facilitated a multidisciplinary team to develop and manage perioperative blood management protocols (CLOT - Coagulation and Lysis Oversight Team), perioperative device management protocols (PACED – Perioperative Cardiac Electrophysiology Devices), perioperative pain management protocols (PCMC - Perioperative Chronic Pain Management Centre), and handoff transition of care protocols. POET is in the process of developing a ReDUCE Initiative (Responsible Drug Use and Cost Effective initiative) to reduce medication cost and waste in the perioperative space tailored to specific patient risk factors, surgery and provider preferences.

**POET Postoperative**

POET postoperative includes goals for enhancement of rapid response capabilities with diagnostic ultrasound for better patient assessment, along with advanced airway and vascular access skills. SUPER (Sonography Use in PErIoperative Medicine) is an initiative to train providers to use ultrasound in rapid response situations, place vascular catheters, and assess pleural and pulmonary pathology in critical care. POET is developing a multidisciplinary acute postoperative service that would involve surgery, medicine, anaesthesiology and nursing working as partners to provide postoperative care management and coordination; to ensure adherence to enhanced recovery care protocols, acute pain and acute-on-chronic medical management, nutrition management and rehabilitation; to reduce postoperative adverse events, and to facilitate throughput and expedited hospital discharge.

**Figure 1** Old paradigm for preoperative screening

PAT – Pre-Anesthesia Testing Clinic; SNF – Skilled Nursing Facility

**Figure 2** POET pre-surgery process

[Diagram showing POET pre-surgery process]
In summary, despite best intentions, a single clinician cannot know and effectively communicate with all the other clinicians involved in the care of a patient regarding a given plan of action, or respond to others’ care plans, in a dynamic fashion. For this reason, the POET fundamental philosophy is to transition from teams of well-intended independent experts to a well-coordinated team of experts to meet the challenges of population health and to contribute to better health for individual patients in the perioperative domain of the healthcare ecosystem.

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The cardiac catheterisation laboratory: anaesthetic trainees’ experiences

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The role of the anaesthetist in the cardiac catheterisation laboratory (‘cath lab’) has evolved significantly in the last decade. With the pre-hospital streaming of suspected acute cardiac events to specialist heart attack centres, as well as improvements in endovascular technologies, anaesthetic input is required for an increasing variety of interventional procedures.1,2

The intermediate level cardiothoracic training unit3 has only a single competence directly related to anaesthesia in the cath lab {CT_IS_08}. Supervised training lists during working hours may be limited. Therefore in an emergency, unfamiliarity with the environment, procedures and team exacerbates the already intensely stressful situation.

Informal feedback indicated that these encounters caused a high level of anxiety amongst trainees and that clinical incidents were underreported. As an exploratory study, we surveyed trainees to examine challenges, stressors and suggest solutions to improve training.

The surveys used a combination of dichotomous, multiple choice, and Likert scaled questions. Both incorporated open-ended questions to identify other categories of stressors, in order to shape further research in the area.

In S1, trainees felt less confident providing anaesthesia in the cath lab compared to the operating theatre (Figure 1). There was no difference in confidence between trainees grouped based on whether or not they had completed their sedation, non-theatre and cardiothoracic units of training.

Results

62 unique responses were received and analysed, 21 in S1 (single-site) and 41 in S2 (pan-London).

100% of trainees in S1 and 85% of trainees in S2 had on-call experience in the cath lab. In S1, only 60% had worked in the cath lab on a teaching list, and only 20% had received training during protected teaching time. In S2, only 30% had formal training in remote-site anaesthesia.

In S1, trainees felt less confident in providing anaesthesia in the cath lab compared to the operating theatre (Figure 1). There was no difference in confidence between trainees grouped based on whether or not they had completed their sedation, non-theatre and cardiothoracic units of training.

In S2, when asked to describe their cath lab experience on a four-point response scale, 72% rated their experience as
‘bad’ or ‘indifferent’ and 17% as ‘good’. No trainees rated their experience as ‘excellent’.

Problems and stressors
20 trainees in S2 who reported a negative experience also identified contributory factors (Figure 2).

Poor handover, communication and team working were reported by 90% of respondents. Elaborating on the reasons for poor communication, 84% of trainees cited unfamiliarity with the team and 71% attributed blame to other team members. Only 25% agreed that they felt an equal member of the team, and 83% felt unclear as to who was leading the team in an emergency.

Other factors included:
- **Remote site anaesthesia** – unfamiliarity with the environment, access to drugs and recovery facilities was cited by 75% of trainees.
- **Technical** – 65% reported problems with equipment, including faulty devices and the inadvertent disconnection of anaesthetic machines from power and gas pipelines.
- **Clinical** – 45% reported managing haemodynamically unstable/complex patients as a stressor.

Trainees’ free-text responses are summarised in Table 1.

Solutions
Over 80% of respondents in S1 and 93% in S2 felt multidisciplinary simulation training would improve crisis management in the cath lab. 84% recommended more regular equipment and drug checks.

Trainees in S2 highlighted the need to specifically focus simulation training on team-working (100% of responses) rather than technical skills (22%). 91% supported the development of standardised protocols for cath lab emergencies via simulation-based clinical scenarios.

Discussion
Emergencies in the cath lab create a range of technical and non-technical challenges for a junior anaesthetic trainee and team as a whole. Yet, unlike the operating theatre, we are unaware of any research specifically investigating clinicians’ experiences in the cath lab. We present the results of two exploratory surveys which suggest that the greatest stressors arise from poor teamwork and unfamiliarity with the cath lab environment, due to lack of supervised experience, rather than with the discrete clinical skills required.

75% of trainees in the pan-London survey identified remote site working as a stressor. As per college guidelines, departmental induction should include detailed orientation to the cath lab. Equipment and access to emergency drugs should be standardised across all clinical areas.

We believe an increase in the number of supervised cath lab sessions to be vital, and would support revision of the curriculum’s learning outcomes and competencies. Although this would lead to a reduction in cardiothoracic surgery sessions, it reflects the increase in endovascular workload and would provide skills and experience transferable to other curriculum areas, including vascular, neuroradiology and critical care.

Alarming equipment problems were identified by 65% of trainees. An equipment and drug check should be performed and documented at the beginning of each shift. This could be led by the trainee responding to emergencies and could double as an opportunity for a team brief, to permit introductions and to address any anticipated problems.

The most striking outcome, however, is the paramount need to improve team working. Often arriving after ambulance handover or during a procedure when a patient has unexpectedly deteriorated, trainees find it difficult to integrate and engage with the cath lab team. It is clear that the principles of crisis resource management – including calling for assistance early, effective handover, leadership and communication, the use of checklists and protocols – are not implemented in the cath lab in the same way as in the theatre environment.

Simulation has been widely employed in other areas of anaesthetic practice, and over 93% of trainees felt it would improve crisis management in the cath lab. Whilst an increase in supervised sessions would
familiarise the trainee with working around the C-arm and other remote site hazards, as most emergencies occur out of hours, simulation provides an opportunity to learn human factors and crisis management skills through complex clinical scenarios. We have developed the multidisciplinary Imperial Cardiovascular Simulation Training (iCAST) programme. It was launched in November 2014 at St Mary’s Hospital and involves a series of high-fidelity simulated cath lab emergencies [Figure 3], followed by a structured consultant-led debriefing session. The course has a strong anaesthetic component, designed to bridge current gaps in cath lab training, with emphasis on communication, teamwork, decision making and crisis handling. Feedback from consultants and trainees involved in pilot sessions has been extremely positive.

Although the current study is limited in size, the results give an invaluable insight into the unique challenges of a cath lab emergency and provide a basis for more extensive research and the development of multidisciplinary cath lab training, such as the iCAST programme. The number of patients undergoing interventional cardiology procedures will continue to increase, and patient safety will only be maintained if the prevailing problems of insufficient remote site practice and poor team working are recognised and overcome.

**References**


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**Table 1** Anecdotes from trainees’ cath lab experiences

| Equipment | “Many times I’ve arrived to find bewildered paramedics and no anaesthetic machine in the room”
|-----------| “Machines found unplugged, no suction, faulty monitoring”
| Protocols | “Complete lack of understanding from cardiology regarding what rapid sequence induction entails”
|           | “Often called down mid procedure to ‘manage the airway’. You’ll never get a cardiologist to stop and do a checklist at this point. It’s hard enough to get them to stop to let you move the C-arm to intubate”
|           | “[the cardiologists] start inserting their access devices without warning before you have had a chance to give any sedation”
| Handover  | “When called to the cath lab mid case I’ve often found it hard to seek basic information from the cardiologists on the situation e.g. patient presentation and actions so far, unlike in a trauma call when handover from the ambulance crew is to the whole team after the airway is established/secured”
|           | “The team should handover what is wrong and what they intend to do – on day one you really have no idea what to expect”
|           | “A short handover from them when they call us down would make a world of difference so that we can do our best to support the patient while they get on with their cath”
| Team Work | “Most trainees only have anything to do with the cath lab staff during emergencies. Not an ideal situation in which to build a working relationship”
|           | “I have had difficulties speaking up when I thought the management was incorrect/inappropriate, due to unfamiliarity with the people that I was working with”
|           | “Lack of situational awareness from cardiology suite staff, who do not seem to appreciate that as the anaesthetist obtaining IV access, securing the airway, giving resuscitation drugs, taking ABGs and attaching monitoring cannot all be done by one person, and that it should be a team approach.”
|           | “As anaesthetists, we also need to put our own egos aside and appreciate that [the cardiologists] are working under a huge amount of stress”
|           | “Often called very late in resuscitation when things are at ‘crisis point’, and asked to ‘intubate the patient’, whilst the cardiologist continues to attempt PCI. As such the cardiology suite team respond to the cardiologist as the team leader - but they often say nothing further, give no history and do not lead the resuscitation, leaving a leadership vacuum”

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**Figure 3** An iCAST simulation session
An anaesthetist at Belsen

J. Gareth Jones  
Formerly Professor Cambridge Clinical School

Oliver C Winterbottom  
Formerly engineer and designer, Lotus cars.

In 1945 the allied armies were advancing rapidly into Germany. On 17 April, under a local truce as the war still raged, the Royal Army Medical Corps (RAMC) 32nd Casualty Clearing Station (CCS) and 11th Light Field Ambulance were two of the first medical units sent into Belsen concentration camp where typhus was out of control.

Of only 8 doctors who entered the camp at that time one, the anaesthetist, was specifically mentioned in the literature about Belsen. He was Captain Walter Carton “Frosty” Winterbottom 32nd CCS (Figure 1) who, before the war, had anaesthetised for Sir Arthur Porritt ** at St Mary’s Hospital, London. Versatility, improvisation and ingenuity are essential qualities of anaesthetists; Frosty deployed these on hundreds of badly-injured men, presenting with unimaginable challenges many times a day in battlezone tents from D-day to the war’s end 12 months later. No “relaxants” were available, the repertoire being pentothal, morphine, Oxford vaporizers, ether, chloroform and the Schimmelbusch mask (see Figure 2). But a new challenge awaited Frosty; to initiate the rehabilitation of 15,000 Belsen inmates who had survived one of the most terrible experiences inflicted by men and women on their fellow beings.

In 1935, the Nazi government of Germany built a 28,000 hectare tank-training school between Hamburg and Hanover on the wooded North German Plain. With the Third Reich’s penchant for comfortable living, the barracks for 15,000 men at Belsen Hohne was surrounded by landscaped grounds having a lake overlooked by a spectacular roundhouse combining ‘The Halls of Valhalla and Blackpool Tower Ballroom’. This included a chandeliered hall with musicians gallery and luxurious residences for Waffen-SS officers. Within the barracks were 50 stables, 40 tank garages, a cinema, 50m swimming pool, a hunting lodge and a 250 bed military hospital.

The political prisoners who built the barracks were housed a mile down the road in 34 wooden huts in a ¼ mile barbed-wire enclosure hidden by trees. In 1940 this became Stalag 311 [XIC], a prisoner of war (PoW) camp for Belgian and French soldiers but, after June 1941, for thousands of Soviet PoWs. Most of the latter died of typhus; a Belsen monument describes “50,000 Soviets tormented to death in fascist German captivity”. From 1943 the camp had a new purpose. Now 100 wooden huts, some of which provided primitive hospital accommodation, housed 4,000 “high value”, mainly Jewish, prisoners of various nationalities, some with visas from neutral countries, and intended to be traded for captured German nationals, materials or cash. Few were exchanged, and by the end of 1944 the Nazis began transferring thousands of concentration camp prisoners westwards ahead of the Red Army advance into Poland. The numbers in Belsen increased rapidly so that by mid April 1945 there were 45,000 in the huttet camp (called Camp 1) and the 15,000 recent arrivals in the Belsen-Hohne barracks (now called Camp 2). Against a background of malnutrition and a 20% incidence of tuberculosis, a massive outbreak of typhus in Camp 1 overwhelmed the indifferent Belsen administration with thousands of unburied corpses. British and Wehrmacht High Commands agreed a truce around Belsen so that the British could take over the camp, ostensibly to prevent the prisoners escaping to infect the population.

On 15 April, Brigadier Glyn Hughes RAMC was the first allied doctor to enter Belsen under the truce. An unknown number, approx 6-10,000, emaciated corpses lay in heaps. Half of the 45,000 living inmates were moribund with malnutrition, gastroenteritis, typhus and TB. Huts designed for 50-100 people had, in some cases, 10 times

** Father of OCW

*** Colonel Arthur Porritt, Bt GCMG, GCVO, CBE, FRCS (1900-94). Olympic athlete, Military Surgeon 21st Army, Surgeon to the Royal Household, President, Royal College Surgeons, 11th Governor General New Zealand.
that number. Every day, more than 500 prisoners were dying. Latrines had ceased to function. Most huts had no beds, and inmates, alive and dead, lay on the floor, naked or in rags soaked in excrement. In some places floor-boards had disappeared and decomposing corpses filled the space beneath. The stench was overpowering. The three immediate problems were to assess, feed and organise hospital care and housing for the living; to kill the lice transmitting typhus, and to bury the dead. At the request of Glyn Hughes, 96 medical students were flown from London on May 1st to help with feeding, draining abscesses and general medical care.

Frosty Winterbottom and the Senior MO, Lt Col JAD Johnston immediately set off to inspect the entire camp and barracks. Not all the survivors were emaciated skeletons; two remarkable Jewish doctors, Drs Ada Bimko from Poland and Ruth Gutman from Austria, had survived extraordinary ill treatment (Bimko’s whole family had been gassed when she was in Auschwitz). Amazingly, these two had maintained a degree of orderliness in their huts seen infrequently elsewhere [see Figure 3]. The British doctors found that all the huts in Camp 1 were unsuitable for the acutely ill, let alone for long-term care for thousands of ambulant people including 500 children. To cope, they needed twelve 1200-bed field hospitals, impossible at this stage of the war. The only alternative was the Wehrmacht Barracks, but 15,000 new prisoners, free of typhus, but many with TB, had been incarcerated there a week before the British arrived. The doctors’ problem was to transfer from Camp 1 the 15,000 people needing hospital-equivalent nursing care and an equal number of ambulant internees. They selected the southern half of the barracks for conversion to hospital accommodation. The plan was to convert the southern half of the barracks to hospital accommodation [Camp 2]. The northern part, supplemented with tents, increased the capacity for ambulant inmates (Camp 3). The barrack buildings were laid out in 20 groups of five, each arranged around a square, each having an excellent canteen/kitchen and two large dining halls. For the hospital they decided that each square would accommodate 700 patients so 11 such squares were requisitioned for the first phase. The Waffen-SS Roundhouse mess could accommodate 500 patients. Further space in the barracks was provided as the fittest inmates were transferred elsewhere. The 250-bed Wehrmacht hospital, already with 2,000 injured German soldiers, would be evacuated. This in itself was a problem because there were 120,000 injured German troops in North Germany, including numerous stationary ambulance trains packed with injured troops.

Frosty Winterbottom was appointed to locate, collect, find buildings for the storage of, and distribute, all in a matter of days, the beds, blankets, linen, clothing, bedpans, urinals, sputum pots, and all the essential stores of a hospital. Starting on 17 April, Camp 1 was completely evacuated to Camp 2 by 20 May then burned to the ground. While clothing and bed linen could be requisitioned from the surrounding populace, it required considerable ingenuity to obtain all the other necessary items at that particular time. Nevertheless, in a week he equipped 7,000 beds by “freezing all he could lay hands upon” around Belsen. In the following week, he equipped a further 7,000 beds. In addition he found thousands of sets of clothing and footwear for the ambulant prisoners, and a group of plumbers and electricians to repair the extensive damage in the barrack buildings caused by the inmates themselves. He found a sewing machine.
and set up a seamstresses’ room, then found fit internee seamstresses who mass produced the “standard Belsen nightie” for the sick, and made dresses, nightdresses and overalls for the ambulant. He set up a hairdressing salon, got hairdressers, manicurists and laundry workers plying their skills, and established and manned, a workshop for repairing radios and bicycles. He converted into a clothing store a former stables, which had recently been the human laundry used to wash, fumigate with DDT and wrap in clean blankets, all the sick inmates transferred from Camp 1 to 2. This store, which he named ‘Harrods’ (Figure 4) because he still had an account there, distributed clothing requisitioned from townships miles around.

Everyone came to him with their supply problems. He was always to be found in his ‘flat’, a canvas screened corner of the Harrods stable loft shared with many others. His divan bed and cushion were brightly covered with red, white and black material from a large silk Nazi flag. His Czechoslovak interpreter was invariably asleep in a nearby chair, but easily awakened to deal with linguistic problems. Like all the internees she had lost all appreciation of time and would fall asleep at any hour. Even at this critical time, he thought it worth trying to normalise the numbed minds of the female internees by ordering 15,000 lipsticks. This caused incredulity in the minds of his colleagues, but delight for the women internees. At that time Harrods store in London had a clientele of 14,000. Two of their bed factories sent 2,000 beds, 5,000 pairs of shoes, 10,000 sets of underclothes and 70,000 blankets. Norma Alexander, one of the Queen Alexandra Nurses (Imperial War Museum SR 15441) noted: “When the patients started getting better, the sister in charge would say ‘Oh they can go down to Harrods’. I thought ‘this is a bit rich’ then it dawned on me that ‘Harrods’ was a hall full of clothes that were taken from the German shops. They would come back with joy on their faces. The men with suits and the women with dresses, shoes, even hats”.

Frosty’s expertise included jazz and the Charleston. So, for RAMC and assistant staff who were doing such heroic work, he organised a nightclub in the barracks called ‘The Coconut Grove’ where they could they find music, alcohol, cigarettes, relaxation and a chance to forget the grimness of their task.

Frosty wrote from Belsen to his wife –

25 April 1945

... I am very busy & have literally not had time to write for five or six days – I will be able to tell you what I am doing soon….This is a colossal job. We are not yet in the postal service & I have not had any of your letters & it has also been difficult to post any to you. I have not seen the papers but I gather we were in the Daily Mirror about 20th or 21st” ...

6 May 1945

... I can tell you now that I am working in Belsen concentration camp & that I am responsible for equipping 13,000 beds for cases of typhus, TB and malnutrition. It is perhaps the hardest work I have ever had to do. Then there are conferences to attend & bed is usually hit pretty late or early in the morning. It really is the most colossal undertaking. I have by now of course got 7,000 beds fairly well equipped and have still got another 7,000 to do ...

28 May 1945

... This dress was made by an internee of the Belsen concentration camp. The material as liberated by me for use in the hospital workrooms which we got going soon after we arrived. I hope the censors & customs will understand the position – in haste ...

The students’ contribution resulted in a fall in deaths in Camp 1 from >500/day when they arrived on 1st May to <100/day by mid May. When Camp 1 was destroyed on 20 May they all transferred to Camp 2. Most had contracted gastroenteritis, six were hospitalised with Typhus. On 28 May 1945, a month after they arrived, the students were scheduled to return to London. Prized souvenirs were SS Panzer dot-camouflaged coats and one was provided to each student by Frosty from his extensive stores. Led by Russell Barton (later a psychiatrist), some of the Westminster students built a raft out of duck boards and beer barrels. As they were putting around the Roundhouse lake a motorcycle dispatch rider arrived to say that their Dakotas were due to take off in 10 minutes. In June 1945, a year after the D-day landing, Frosty returned to England via Denmark, staying there with Colonel Lipscomb who wrote one of the first Lancet papers on Belsen. Frosty had an Alsatian guard dog puppy, Suzanne, liberated from Belsen, but left it with a Danish farmer because of UK quarantine restrictions. After the war Frosty became a GP in Olney in Buckinghamshire, with anaesthetic sessions in Northampton. He died in 1969 aged 63.

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References

The Wessex primary exam support network

Julie Onslow
Training Programme Director, Wessex

The Royal College of Anaesthetists primary exam has undergone a number of changes in the last few years.

The multiple-choice questions now consist of 60 true/false answers and 30 ‘single best answer’ questions; the second part of the exam has been split into a structured oral examination (SOE) and oral structured clinical exam (OSCE).

Core anaesthetic trainees have this exam to complete and a plethora of work-based-assessments to work through in their first two years of training.

The primary exam is not an easy exam to pass; the balance our trainees need to strike between study, work and home life is not easily achieved. The evolution of trainees’ lives here in Wessex is noticeable. For many this is their first post-graduate exam, and they no longer have the luxury of full-time study. More demanding shift patterns have led to an increase in the time trainees have to spend driving their cars. The tendency to live off site, i.e. away from the hospital, decreases potential colleague support time during exam study periods.

As training programme director for the core trainees in Wessex, I have studied the primary exam pass rates here. For the primary MCQ in the last three sittings the pass rate has varied from 46-55.1%, and for the last three sittings of the OSCE/SOE component from 55.4% to 57.2%.

Currently, I have 5.1% of my core trainees in extended time due to exam difficulties.

Here in Wessex we offer a scientific principles course aimed at the MCQ, and locally two OSCE/SOE courses are available. In each hospital within the rotation, a robust term-time primary FRCA tutorial programme is on offer too.

Despite this, a number of trainees approach me with difficulties in passing the exam. With this in mind we have devised a number of component areas to help work towards exam success.

Networking
It is vitally important to prepare for the revision period. I place trainees who are getting ready to revise in touch with others who are taking or have just taken the exam. This enables trainees to have a current and useful textbook list and an online resource list. These conversations are useful in providing support to them all as they compare notes.

Courses
I am able to direct each trainee to the exam courses that they will find relevant.

Coaching
Exam success is often related to confidence and technique, as well as to knowledge and clinical experience. We have both past and present examiners within our region, and all of them have kindly agreed to provide individual help with technique and coaching to trainees to improve their chances of success.

Professional support unit
Within Health Education Wessex, the Patient Safety Update can provide exam help, and individuals can access support, preparation and planning advice, and coaching.

Wessex viva network
In each hospital, there is a wealth of oral examination practice to be utilised. I have the contacts in each location, and I can put the trainees in touch with the consultants who are running this branch of practice and the trainees can touch base with others who are taking the same exam as themselves.

Strengthened tutorials
Tutorials are a chance for trainees to get together and learn. Within our region we are looking at collaboration of hospitals in the east and west of the region to provide tutorials for more trainees than can be done with tutorials in each hospital, with maybe single-figures of trainees at each level being brought together. These tutorials can incorporate resilience training too, with the aim of increasing trainees’ confidence, and their ability to cope with the stress of work and the exam and balance their lives.

Listening
Educational supervisors, college tutors, and myself as training programme director, have the ability to listen, and this skill must not be underestimated. We all understand just how difficult an exam can be.

I see myself as being able to tailor exam support for individuals, and Wessex can now provide an enhanced form of exam support for all of its core trainees.
Exam success is often related to confidence and technique, as well as to knowledge and clinical experience.
College Tutors Meeting

Poster competition winners

At the recent College Tutors Meeting in Brighton, the submissions for the annual Poster Competition were judged. Abstracts had been invited which represented work to improve the delivery and quality of Anaesthesia, ICM & Pain Medicine training in the UK. Over 60 abstracts were received, of which 40 were selected for display as posters. The three highest-scored abstracts were selected for oral presentation at the meeting.

The three oral presentations were judged on the day. Dr James Wilson was awarded first place, with Dr Tom Mount in second, and Dr Emma Plunkett in third. All received the President’s Prize. The presentations were all very professional, and enjoyed by the audience. The abstracts are printed below:

Novel use of Biopsychosocial Model to Identify Training Deficits and Target Personal Development

Dr J Wilson Wigan Wrightington and Leigh NHS Foundation Trust

The Biopsychosocial model (BSPM) described by Blascovich explains how an individual’s perception of challenge and threat, relating to an upcoming scenario/event, can predict their performance[1]. Individuals perceiving a challenge tend to perform better than those that perceive a threat. In aviation training this correlated with overall performance during a critical incident type scenario (engine failure) [2]. Does this phenomenon correlate with experience of anaesthesia trainees?

A survey was sent to NW Deanery trainees. Challenge threat appraisal was calculated by asking two questions; 1) ‘How demanding do you expect the scenario to be?’ and 2) ‘How able are you to cope with the demands of this scenario?’ Scores for each were ranked on a Likert scale of 1 (not at all) to 6 (extremely). A Demand Resource Evaluation Score (DRES) was calculated by subtracting demands (question 1) from resources (question 2) [3]. More positive scores suggest perception of challenge rather than threat.

The scenarios surveyed covered subspecialty areas and critical incidents. DRES correlated with experience and grade. Individual scenarios showed that sub specialties such as Obstetrics (Category 1 LSCS scenario) showed a strong correlation between DRES and experience. DRES scores for critical incidents (CICV, MH, Anaphylaxis and LA Toxicity) showed no correlation with experience.

When an individual’s DRES results are analysed they demonstrate areas where the trainees perceive themselves as more confident. Figure 1 shows a radar graph demonstrating the sub-specialty areas surveyed and the responses from a higher trainee.

It seems reasonable to suggest that an individual’s response to demand/resource questions can identify areas where they lack experience or confidence clinically. This can be used to target specific areas via their Personal Development Plan and even inform placement and module choice.

References
In-situ simulation: a smoother induction?
Dr T Mount, Dr C Allen, Dr K MacLennan. Central Manchester Foundation Trust

Induction to the working environment is an essential process which must cover a number of key areas, usually within a challenging timeframe. In-situ simulation, in which participants undertake simulated scenarios in the real work environment, has been described in the context of improving team interaction in the workplace and in trialling new medical facilities, but not previously as part of the hospital induction of medical staff.

In our institution, in-situ simulation is used as part of the anaesthetic trainee induction process to the cardiac angiography suite, emergency department and general theatres, and as part of the induction of both the anaesthetic and obstetric trainees to the delivery suite. Standardised self-report questionnaires are filled out pre- and post-simulation, and typically show an improvement in trainee confidence following the simulation sessions. The aim of our study was to further assess the effectiveness of in-situ simulation for induction into the work environment.

A total of ten follow-up interviews were conducted at 3 to 6 months with anaesthetic trainees to explore how their clinical experiences may have been influenced by the in-situ simulation. Semi-structured interviews were conducted and audio-recorded by TM and CA, who then separately analysed the interviews and then agreed themes.

A number of key themes emerged from the interviews. The scenarios were largely considered useful, accurate and time-efficient, and applicable generally as well as specifically to the Trust. The ‘cardiac catheter-lab scenario emerged as particularly valuable, which appeared to be related to high anxiety about this environment, due to unfamiliarity, previous clinical experiences in other angiography suites, or a lack of specific previous training to this environment. The MDT aspect of the obstetric induction was considered by many trainees to be of great value.

Our institution employs a novel use of in-situ simulation as part of workplace induction, which may be of interest to all departments with an intake of anaesthetic trainees. Although specialist simulation equipment may be used, this is not essential, as the ‘high-fidelity’ element is largely due to the workplace setting, and so would be able to be replicated within existing departmental resources. Qualitative analysis suggests that it is felt by trainees to be an effective, accurate and efficient means of clinical induction, and may be of particular benefit in the cardiac angiography suite and the delivery suite. No funding was received for this study.

References

College Tutors Meeting: Poster Competition 2017
Details of the next trainee poster competition in conjunction with the College Tutor’s Meeting 2017 will be available soon. Further information will be posted on the College Website at www.rcoa.ac.uk and will also be available through your College Tutor.
Less-than-full-time (LTFT) Matters: a national survey of LTFT training
Dr E Plunkett, Dr A Costello, Dr SC Gibb

The 2015 GMC survey reported that 11.7% of all trainees were working LTFT. Anaesthesia was the 6th most popular specialty by percentage, with 12.2% training LTFT, an increase from 8.7% in 2010. Anecdotally, access to and support for LTFT training is variable across the country. We sought to establish how LTFT training in anaesthesia functions in each region, the challenges faced and any particular areas of good practice.

In 2015 the GAT Committee established a LTFT trainee contact in all 29 schools of anaesthesia in Great Britain and Ireland, forming an AAGBI LTFT network, with an email account dedicated to this: ltft@aagbi.org. We asked each of these contacts to complete an online questionnaire about LTFT training in their region, focusing on communication, support, availability of information and any problems encountered.

We had at least one response from every school of anaesthesia between April and October 2015. Where more than one response was received, the results were amalgamated. The table below summarises the resources and initiatives available in each school to support LTFT trainees.

Email was the most common method of communication about LTFT issues (n=15). Seventeen schools have LTFT information on a Local Education and Training Board (LETB), school or other website, and eight schools have closed Facebook groups for LTFT communication. Representatives from several schools reported problems finding out who the LTFT trainees were in their region; needing to rely on word of mouth for this.

A wide range of issues affecting LTFT trainees was reported which included: pay problems (n=18); difficulty achieving educational objectives (n=13); culture not supportive or valuing of LTFT trainees (n=10); difficulty organising rota (n=10); inequitable access to educational opportunities (n=8); lack of support from school or LETB (n=6); lack of access to LTFT posts (n=4). Only three schools reported having no issues. Eight schools gave positive comments about LTFT training being well supported locally.

The questionnaire results have been shared with the Royal College of Anaesthetists (RCoA) Bernard Johnson Advisor for LTFT training, and will be discussed at the joint RCoA and AAGBI LTFT seminar in May 2016. The hope is that formation of the AAGBI LTFT network and having a regular national LTFT day will lead to improvement of issues affecting LTFT trainees, and allow sharing of resources, ideas and good practice.

<table>
<thead>
<tr>
<th>Resource / Initiative</th>
<th>% of schools (n, total = 29)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTFT Consultant Specialty Advisor</td>
<td>86% (25)</td>
</tr>
<tr>
<td>School trainee meeting where LTFT issues can be raised</td>
<td>76% (22)</td>
</tr>
<tr>
<td>Information locally available about LTFT training (e.g. A-Z of LTFT training in Anaesthesia and Intensive Care Medicine.)</td>
<td>90% (26)</td>
</tr>
<tr>
<td>Return to work programme</td>
<td>59% (17)</td>
</tr>
<tr>
<td>Return to work course run locally</td>
<td>41% (12)</td>
</tr>
<tr>
<td>Interest in setting up a return to work course</td>
<td>34% (10)</td>
</tr>
</tbody>
</table>
Senior Fellows Club Meeting  
14 June 2016

About 100 members were present at the College, and Ian Calder was in the Chair. The Club met nine days before the Referendum on the UK’s membership of the European Union. The Chairman resisted the temptation to enquire about remain/leave voting intentions, fearing that the harmony of the day might be disturbed, but a show of hands indicated that several present were still undecided. He reminded members that the Leave campaign had indicated their intention to abolish bus passes for the elderly.

Ann Ferguson’s astonishing compendium of things to do in London was received with gratitude and respect, and possibly some guilt by London-based members, and just reading her research makes one feel a little more cultured.

Our President addressed us with typical cheerfulness, though he did allow that there was “a lot going on”, and brought us the College’s Strategic Plan for 2016-21. Liam spoke of the recent difficulties caused by Ministers misinterpreting scientific data, and told us that a Director of Communications will be appointed, who will attempt to improve the interface between us, the public, and the government. He also mentioned that the College was investigating ways of maximising income from its spaces and facilities. Visions of the sort of “hot-desking” so wonderfully lampooned in the BBC spoof “W1A” sprang to mind - will there be a “Head of Better” in Churchill House? We were all pleased to hear that the BJA now boasts the highest impact factor of any anaesthesia journal, but sorry to be told that a majority of departments currently depend on locum appointments. A lively discussion had to be cut short to allow time for the main speaker.

Our Invited Speaker was Dr Simon Harris, who addressed us on “Horatio Nelson, his Wounds, the Seventh Commandment, and the Festival of Priapus”.

Simon has pursued a twin track career as a consultant anaesthetist in Kings Lynn and as a professional historian. His great-great-grandfather fought with Nelson at Boulogne, his grandfather was at Jutland with Jellicoe, whilst an uncle was with Cunningham at Matapan, so it is unsurprising, that military, and naval history in particular, is his field. He has written the definitive biography of Admiral Sir Cloudesley Shovell, whom he considers an even more interesting character than Nelson.

In the first section of his lecture, Simon dealt with Nelson’s wounds – a blinded eye in Corsica, an abdominal wound at Cape St Vincent, an amputated arm at Tenerife, a head-wound at Aboukir Bay, and his fatal wounds at Trafalgar. The detail was fascinating, but horrifying too. The most astonishing story was of the conduct of Capitaine Du Petit Thouars of the Tonnant, who having lost both legs and an arm during the battle of Aboukir Bay, had himself propped up in a barrel of wheat and continued to direct his crew.

The Festival of Priapus is no longer publicly celebrated. Sir William was an observer rather than a participant, and Dr Harris compared Sir William’s interest in the festival to our recent fascination with ‘Bunga Bunga Parties’. We shared Dr Harris’ dismay when one of Sir William’s collection of model phalluses disintegrated during an examination in the vaults of the British Museum, but were glad to hear that restoration proved possible.

Dr Harris gave us an erudite and fascinating lecture about extraordinary times and people. The depth of his scholarship was clear to us all and it was a privilege to hear him.

The next meeting of the Club will be in York Railway Museum on Thursday 3 November. The Speaker will be Mr Howard Driver of The North Yorkshire Mountain Rescue Service.
As we were
by Dr David Zuck, History of Anaesthesia Society

I put in a six-weeks’ course of dissection at Guy’s, and there I was invited to witness my first operation, in a theatre on the top floor. I shall never forget it.

In an ante-room I was fitted with a white cap, mask and gown before entering the holy of holies where all were similarly attired. Then a girl with an acute appendix, days old, was wheeled in on a trolley and transferred to the operating table. She seemed to be joined to the anaesthetist like a Siamese twin by a corrugated rubber tube connecting a mask over her face to the man in control of the Clover’s inhaler for nitrous oxide and ether. She was deeply blue in the face, and her breathing was noisily stertorous. It was during a heat wave. The sun blazed down on the glass roof, and the temperature must have been about ninety. Soon the hot, humid atmosphere was filled with the pungent, sickly smell of ether as the bag blew out and sucked in with her laboured respirations. Her abdomen was exposed: and towels clipped on the skin so as to leave only the field of operation uncovered; and, all being ready, Mr. Hughes posed his scalpel and incised the living, virgin flesh. Paradoxically, it was far more horrible to me than dissection of the cadaver. Nevertheless, I had arrived at the moment for which I had been studying anatomy, and I glued my eyes to the retracted wound edges in the hope of identifying the structures revealed. I could see little from where I stood on the outskirts of a group of acolytes surrounding the High Priest as he made sacrifice and groped with his gloved hand among the human entrails. Suddenly there was a gush of foul-smelling pus which welled all over the abdomen and overflowed the sterile cloths into a kidney bowl ready to hand. The smell is peculiar to the products of the Bacillus Coli. It is quite indescribably filthy and far worse than any ill-tended latrine. I found it increasingly difficult to focus on the wound, and I remembered no more until I came to, flat on the floor of the corridor outside, attended by two amused but sympathetic students.

The cold-blooded cutting of a live human being, the girl’s cyanosed face and horrible breathing, the heady stench of ether and the stinking pus, added to the heat of the theatre, had been too much for me. It was common to faint in those days. Students get over it as increased knowledge and technical interest overcome the unpleasantness; but I wonder what benefit can be derived by the medically uneducated masses who are allowed nowadays to see operations on the television - beyond the satisfaction of morbid curiosity.

Medicine and surgery have made vast strides since 1914. Anaesthetics were still in the ‘rag and bottle’ stage of pouring chloroform, ether, or a mixture of the two, on a gauze mask held over the patient’s face. Worse still was induction by Clover’s inhaler - an expanding rubber bag from which nitrous oxide and ether were pumped into the patient who became frightfully cyanosed and stertorous, and was always horribly sick on coming round. Patients were seldom properly relaxed for the abdominal surgeon’s exploratory purposes, and shock was far greater.

Fractured limbs were ‘set’ by manual traction only, and bandaged to padded pieces of wood. The routine ‘daily massage and movement’ of the neighbouring joints encouraged displacement of the fragments. Weight-bearing in fractures of the tibia and fibula was not possible until full union had occurred, and so, after a month or two, these cases began to hop on crutches in loose padded plaster casts which did not properly immobilise the fracture; nor, of course, did they permit of weight-bearing and natural function.

Operative surgery at St George’s was excellent but, unfortunately, outside the hospital early diagnosis lagged. Cases of acute appendicitis were usually ‘cooked’ at home by the GP for days before perforation or generalised peritonitis occurred. Drainage by wide rubber tubes was the rule rather than the exception. Foul stinking pus discharged; inflamed stitch sinuses added to the misery, and the infected wound took about five weeks to heal. But, happily, even while I was still a student, the ‘acute abdomen’ was sent earlier to hospital, and this made possible clean wounds which heal by ‘first intention.’

Extracted from ‘Cambridge Doctor’ by Rex Salisbury Woods [published by Robert Hale, London, 1962]. Dr. Woods (1891-1986) had an eminent career as a multitalented general practitioner, very prominent in sport. A Cambridge Blue for putting the shot, he represented Great Britain twice at the Olympics. He served in the RAMC during both world wars. A biography will be found in Plarrs Lives of the Fellows of the Royal College of Surgeons. Some of his opinions, although in line with his times, would not be thought politically correct today.
Report from Council

At a meeting of Council held on Wednesday, 15 June 2016, the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

**Regional Advisers**
**South West Peninsula**  
Dr Chris Seavell in succession to Dr Peter Davies

**Deputy Regional Advisers**  
**North West**  
Dr Karen Kidner in succession to Dr I C Brocklehurst

**College Tutors**  
**Anglia**  
Dr H Underhill (Addenbrookes Hospital) in succession to Dr M E Jones

**Northern Ireland**  
Dr E Davis (Antrim Area Hospital) in succession to Dr K A A Abraham

**West Yorkshire**  
Dr S Kritzinger (Bradford Royal Infirmary) in succession to Dr R Akerele

**South Thames East**  
*Dr R Wadhwani (Kings College Hospital)

**Leicester & South Trent**  
Dr R Ferrie has volunteered to be acting tutor covering for Dr E Copley at Kettering General Hospital

**West Midlands North**  
Dr L Craker (Royal Stoke University Hospital) in succession to Dr A I Augustine

**West Midlands South**  
Dr R Danha (University Hospital, Coventry and Warwick) in succession to Dr K Ramachandran

Dr K Dasgupta (George Elliot Hospital) in succession Dr D Khare

**Head of Schools**  
There are no notified appointments this month.

Certificate of Completion of Training  
Council noted recommendations made to the GMC for approval, that CCTs/CESR (CP) be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia.

The doctors whose names are marked with an asterisk have been recommended for Joint CCTs/CESR (CP) in Anaesthesia and Intensive Care Medicine and those with a # have been awarded a CESR (CP)

**London – Imperial**  
Dr Daniel Peter Turner

**North Central**  
Barts and the London

**South East**  
Dr Ramai Santhirapala*

**South West Peninsula**  
Dr Maytinee Lilaonitkul

**Severn**  
Dr J Tuckey (Royal United Hospital, Bath) in succession to Dr C Seller

**Hull, Yorkshire & East Coast**  
Dr Alison Byard

**Leeds and Bradford**  
Dr Binu Easaw#

At a meeting of Council held on Wednesday, 20 July 2016, the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

**Regional Adviser**  
There are no notified appointments this month.

**College Tutors**  
**North Thames Central**  
Dr C Kidel as acting Tutor Royal Free Hospital

**West of Scotland**  
Dr T Madamombe (Southampton University Hospital)  
*Dr M Girgis (Poole Hospital)

**South West Peninsula**  
Dr L Alderson (Derriford Hospital) in succession to Dr J Elliott

**Severn**  
Dr J Tuckey (Royal United Hospital, Bath) in succession to Dr C Seller

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Council noted recommendations made to the GMC for approval, that CCTs/CESR (CP) be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in anaesthesia.

The doctors whose names are marked with an asterisk have been recommended for Joint CCTs/CESR (CP) in Anaesthesia and Intensive Care Medicine and those with a # have been awarded a CESR (CP).

**Anglia**  
Dr Gokulnath Rajendran*  
Dr Andrew Holder*  
Dr Edmund Keng Yee Quak  
Dr Anna Margeret Jane Hutton  
Dr Kim James Wild
Nottingham
Dr Vaidyanathan Ramanathan

East of Scotland
Dr Andrew John Dalton
Dr Lawrence Lok Man Li

South East
Dr Smitha Honnesh

Mersey
Dr Rebecca Mary Maureen Gale
Dr Richard Lewis Dodwell
Dr Emma Jane Jackson
Dr Sianedd Bethan Elliott
Dr Gerald Francis Smith
Dr Andrew Robert Prenter

Stoke
Dr Rajeev Kumar Aggarwal

West of Scotland
Dr Andrew Clark
Dr William Dominic Strachan
Dr Anne-Louise Welsh

East Yorkshire (Hull/York)
Dr Vivek Kumar Sinha

Leeds and Bradford
Dr Michal Luniewski

Sheffield
Dr Kris Benjamin Bauchmiller
Dr Tomasz Grzegorz Bendinger
Dr Helen Elizabeth Ellis

Northern Ireland
Dr Denver Glasgow

North of Scotland
Dr Sheila Clarke #

North West
Dr Leanne Marie Darwin
Dr Richard Ramsaran
Dr Anthony Joseph Wilson
Dr Saravanan Shanmuganathan

South West Peninsula
Dr Thomas Paul Lawson

Severn
Dr Catherine Frances Bryant
Dr Kate O’Connor

Council received and approved the list of Fellows by Examination from June 2016.

Akindele Olubukola
Al Sultan Saba Mohammed Mahmood
Al-Kadhimi Samuel
Ibrahim Abdelwashab Alkholany Mahmoud
Allan Katie Anne
Allison Carrick Andrew George
Alva Sachin Krishna
Angus William Harry
As-Sultany Sara
Bandara Lalindra Koshala
Barrett Stephen Thomas John
Bartram Aimee Victoria
Bell Victoria Elizabeth
Blood Laura Louise
Bonar Robert
Bowness James Simeon
Boyce Antonia Roberta Anne Marie Mullane
Bradburn Scott Arthur
Bramma Yvonne Louise
Brandwood Matthew Gordon
Breckenridge Fiona
Browell Christopher
Bruce-Hickman Kara
Burgess Jennifer Lynne
Burton Andrew James
Byford-Brooks Anthony Patrick
Carpenter Adam Benjamin
Chamberlain Andrew Kenneth
Chana Sanjeet Paul Singh
Chandrasekharan Shardha
Chapman Kerensa Elizabeth
Charles Robert James
Charlesworth Beatrice Edwina Mary
Chaudhary Atif Ahmed
Cheuk Sarah Jane
Clarke Thomas Charnock

Coathup Rachel Anna
Coleman Thomas
Cox Nicola Hayley
Cox Nancy Diana
Crockett Douglas Crymble
Cullen Stephen Gerald
Dart Philip James
Davies Rhys Lewis
Denning Simon William
Devlin David Patrick
Dhotar Gagandeep
Dodd Amy Frances
Doyle Richard John
Duckham Antonia Emily
Duffield Charles Alexander Beaumont
Eccles Jennifer Anne
Edwards Victoria Mary
El-Dalil Phillip Rafique
El-Kheir Anthony Anwar
Ellis Richard John Bowes
Jeremy Fabes
Farley Christopher David
Fay James Luke Anthony
Gajendragadkar Pushpaj
Garwood James Lloyd
George Simon
Gilbert Alice
Gilbert-Kawai Edward Timothy
Girdler-Hardy Thomas Paul
Glenn Amy Virginia
Glover Stephen John
Golhar Anil Singh
Gorur Paavan Ananth
Graley Katherine Elizabeth
Grant Andrew Peter
Grenfell Suzanne Clare Brabazon
Hall Christopher
Hall David Peter
Haniff Amr
Hawkins Joe William Thomas
Heath Charlotte Beverley
Hettiarachchi Dhulanjie Natasha
Hillier Stephen
Ho Selina
Howell Samuel Alabaster
Howle Ryan Christopher
Hunt Richard Edward
Hutchins David Charles Jarvis
Ignacka Aleksandra Anna
Javaid Amar
Jhalini Jawaheer
Jolly Erica

ERRATUM – JULY ISSUE
Regrettably a spelling error was made in this list in our July issue.
The correction is:
West of Scotland
Dr Katrina Dick

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Dr Katrina Dick

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The correction is:
West of Scotland
Dr Katrina Dick
Appointment of Members, Associate Members and Associate Fellows

The College congratulates the following, who have now been admitted accordingly:

Associate Fellows:
Dr Miklos Szappanos
Dr Derick D’Souza
Dr Marc Gimenez Mila

Members:
Dr Istvan Darok

Associate Members:
Dr Ines Lojna Funtak
Dr Abhijeet Rajan Mishra

FRCA Examinerships 2017–2018

The College invites applications for vacancies to the Board of Examiners in the Fellowship of the Royal College of Anaesthetists, for the academic year 2017–2018. Examiners will be recruited to the Primary examination in the first instance. The number of Examiners required will reflect the number of retirements from the current Board of Examiners.

Applicants shall be assessed against a comprehensive Person Specification which, along with the Job Description and applications forms for this role can be downloaded from the examination pages of the College website (http://rcoa.ac.uk/xlb6).

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

a Essential
1. Fellow by Examination, a Fellow ad eundem, or a Fellow by election of the Royal College of Anaesthetists.
2. In good standing with the College
3. Holds full registration, without limitation, with the GMC
4. At least five years-experience as a substantive Consultant/SAS grade
5. Shall currently be active in clinical practice in the NHS
6. On 1 September 2017 shall have the expectation of completing at least 10 years as an FRCA examiner
7. Can demonstrate active involvement in the training and assessment of trainees.
8. Good written and verbal communication skills
9. Ability to work as part of a team
10. Documentary evidence of satisfactory completion of Equal Opportunities training in the last three years and willingness to undertake further exam specific E&D training on an annual basis.
11. Able to commit to long-term and active involvement to examiner duties including the ability to devote a minimum of 11 days per academic year to the role. This includes both the delivery and development of the examinations
12. Within the past five years shall have visited a Primary or Final FRCA examination.

b Desirable
1. Shall demonstrate a special interest[s] directly relevant to the balance of expertise required in the Board of Examiners.

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

The closing date for receipt of completed application forms is Monday, 10 October 2016.

NIAA Vacancy: Grants Officer

Applications are invited for the position of Grants Officer for the National Institute of Academic Anaesthesia (NIAA).

This is a three-year fixed term appointment to strategically promote, develop and manage a process that will further the vision of the NIAA to facilitate high profile, influential research.

The post holder will provide specialist advice to grant applicants, liaise with funding partners and specialist societies, and act as the outward face of the NIAA grants scheme including presenting at meetings and representing the NIAA on external panels.

The post is supported by the cost of one period of professional activity (1 PA) per week; back-filled to the post-holder’s employing organisation, in order to enable the successful candidate to dedicate a minimum of four hours per week to the role.

You can find out more information and download a full job description and person specification for this role from the NIAA website: www.niaa.org.uk.

Deadline for applications: Monday, 12 December 2016 at 5 pm
Interviews will take place in January 2017.
## Consultations

The following is a list of consultations which the RCoA has responded to in the last two months:

<table>
<thead>
<tr>
<th>Originator</th>
<th>Consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS England</td>
<td>Developing a method to assist investment decisions in specialised commissioning: next steps</td>
</tr>
<tr>
<td>Association of Anaesthetists of Great Britain and Ireland</td>
<td>Guidelines on Consent for anaesthesia 2016</td>
</tr>
<tr>
<td>NHS Litigation Authority</td>
<td>Clinical Negligence Scheme for Trusts Pricing Consultation</td>
</tr>
<tr>
<td>Royal College of Surgeons</td>
<td>Revised commissioning guide on tonsillectomy</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>Draft Intravenous fluid therapy in children and young people in hospital quality standard</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>MTG3 CardioQ - Guidance Review Consultation</td>
</tr>
<tr>
<td>British Society for Haematology</td>
<td>Draft guideline on peri-operative anticoagulation</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>Topic engagement - care of dying adults in the last days of life</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>Consultation on draft blood transfusion quality standard</td>
</tr>
<tr>
<td>Care Quality Commission</td>
<td>NHS Patient survey programme</td>
</tr>
<tr>
<td>NHS England</td>
<td>Establishing and improving Emergency Vascular care in networks, meeting 7DS standards</td>
</tr>
<tr>
<td>NHS England</td>
<td>Strengthening Major Trauma care in networks across 7 Days</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>Draft guideline on End of life care for infants, children and young people</td>
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<tr>
<td>National Institute for Health and Care Excellence</td>
<td>Draft Transition from children’s to adults’ services quality standard</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence</td>
<td>Consultation on Abbreviated Technology Appraisal (ATA) Process</td>
</tr>
</tbody>
</table>
7 September 2016
LEADERSHIP AND MANAGEMENT: PERSONAL EFFECTIVENESS
RCoA, London
£220

7-9 September 2016
UPDATES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT
RCoA, London
£490

9 September 2016
FPM EXAM TUTORIAL
RCoA, London
£95

12 September 2016
ADVANCED CENTRAL VENOUS ACCESS FOR ANAESTHETISTS
RCoA, London
£240 (£180 for RCoA registered trainees)

14 September 2016
PAEDIATRIC EMERGENCY MANAGEMENT FOR THE ANAESTHETIC TEAM
RCoA, London
£240 (£180 for RCoA registered trainees)

16 September 2016
ULTRASOUND WORKSHOP
RCoA, London
£240 (£180 for RCoA registered trainees)

19-20 September 2016
CPD STUDY DAYS
RCoA, London
£355 (£270 for RCoA registered trainees)

22-23 September 2016
FICM: EXAM PREP COURSE
The Rose Bowl, Leeds
£270

26-27 September 2016
ANAESTHETISTS AS EDUCATORS: TEACHING AND TRAINING IN THE WORKPLACE
RCoA, London
£425 (£320 for RCoA registered trainees)
FULLY BOOKED

28 September 2016
ADVANCED AIRWAY WORKSHOP
RCoA, London
£240 (£180 for RCoA registered trainees)

28 September 2016
CPD STUDY DAY
The Waterfront Hall, Belfast
£200 (£150 for RCoA registered trainees)

3 October 2016
DEVELOPING WORLD ANAESTHESIA
RCoA, London
£150

5 October 2016
A CAREER IN ANAESTHESIA
RCoA, London
£45

12 October 2016
AIRWAY WORKSHOP
The Teacher Building, Glasgow
£240 (£180 for RCoA registered trainees)

18 October 2016
A CAREER IN ANAESTHESIA
The Rose Bowl, Leeds
£45

20 October 2016
CPD STUDY DAY: UPDATE ON INTRA-OPERATIVE MONITORING
RCoA, London
£200 (£150 for RCoA registered trainees)

21 October 2016
ANAESTHETISTS AS EDUCATORS: AN INTRODUCTION
RCoA, London
£220 (£165 for RCoA registered trainees)
FULLY BOOKED

31 October – 1 November 2016
INTRODUCTION TO LEADERSHIP AND MANAGEMENT: THE ESSENTIALS
RCoA, London
£395

2 November 2016
AIRWAY WORKSHOP
RCoA, London
£240 (£180 for RCoA registered trainees)

3 November 2016
ANAESTHETISTS AS EDUCATORS: ANTS (ANAESTHETISTS’ NON-TECHNICAL SKILLS)
RCoA, London
£220 (£165 for RCoA registered trainees)
3-4 November 2016
WINTER SCIENTIFIC MEETING (JOINT WITH THE SSA)
The Chester Hotel, Aberdeen
£270 (£205 for RCoA registered trainees)

4 November 2016
CPD STUDY DAY
Mercure Hull Royal Hotel, Hull
£200 (£150 for RCoA registered trainees)

9 November 2016
ANAESTHETISTS AS EDUCATORS: ADVANCED EDUCATIONAL SUPERVISION
Novotel Hotel, Sheffield
£220

9 November 2016
LIFE-THREATENING ASTHMA, SEPSIS, EPILEPSY AND DIABETES IN CHILDREN MEETING (JOINT WITH THE RSM)
RSM, London
Please see the RCoA website for event fees

9 November 2016
UK PERIOPERATIVE MEDICINE CLINICAL TRIALS NETWORK AUTUMN MEETING
The Studio, Birmingham
£45

10-11 November 2016
UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE
Edinburgh Royal Infirmary
£450

16 November 2016
GASAGAIN (GIVING ANAESTHESIA SAFELY AGAIN) COURSE
Bradford Royal Infirmary
£240

18 November 2016
CPD STUDY DAY: ANAESTHESIA FOR ORTHOPAEDIC SURGERY
RCoA, London
£200 (£150 for RCoA registered trainees)

21 November 2016
CLINICAL DIRECTORS MEETING (JOINT WITH THE AAGBI)
RCoA, London
By invitation only

22-23 November 2016
ANAESTHETISTS AS EDUCATORS: TEACHING AND TRAINING IN THE WORKPLACE
RCoA, London
£425 (£320 for RCoA registered trainees)
FULLY BOOKED

24-25 November 2016
WINTER SYMPOSIUM: CONTROVERSIES IN PERIOPERATIVE PRACTICE
RCoA, London
£395* (£295* for RCoA registered trainees)

26 November 2016
CONTINUING PROFESSIONAL DEVELOPMENT DAY
RCoA, London
£240* (£180* for RCoA registered trainees)

* A joint rate of £490 (£370 for RCoA registered trainees) is available for those attending both the RCoA Winter Symposium and the Continuing Professional Development Day

28 November 2016
LEADERSHIP AND MANAGEMENT: WORKING WELL IN TEAMS ... AND MAKING AN IMPACT!
RCoA, London
£220

29 November 2016
ANAESTHETISTS AS EDUCATORS: SIMULATION UNPLUGGED
RCoA, London
£220 (£165 for RCoA registered trainees)

30 November 2016
PATIENT SAFETY CONFERENCE
Royal College of Physicians, Edinburgh
£215

2 December 2016
FPM 9TH ANNUAL MEETING: CORE TOPICS IN PAIN MEDICINE
RCoA, London
£195 (£140 for RCoA registered trainees)

9 December 2016
RCoA CAREER DAY
Manchester Conference Centre
Free of charge

12 December 2016
NATIONAL INSTITUTE FOR HEALTH RESEARCH MEETING
RCoA, London
Fee to be confirmed

12 – 14 December 2016
UPDATES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT
The Royal York Hotel, York
£490

14 December 2016
JOINT RCoA/LSORA REGIONAL ANAESTHESIA PRACTICAL WORKSHOP
RCoA, London
£260* (£195* for RCoA registered trainees)

15 December 2016
JOINT RCoA/LSORA REGIONAL ANAESTHESIA SYMPOSIUM
RCoA, London
£200* (£150* for RCoA registered trainees)

*A reduced rate of £360 (£270 for RCoA registered trainees) is available for those attending both the Joint RCoA/LSORA Regional Anaesthesia Practical Workshop and the Joint RCoA/LSORA Regional Anaesthesia Symposium.
ADVANCED AIRWAY WORKSHOP

28 September 2016
RCoA, London
£240 (£180 for RCoA registered trainees)
Organiser: Dr R Bhagrath

Overview
This workshop is aimed at consultants and senior trainees wishing to gain advanced airway skills using experienced small group teaching and hands-on practice.

Workshops
- Awake fibreoptic intubation (2A01)
- Front of neck access and alternative oxygenation techniques (BA01)
- Guidelines (1C02)
- The paediatric airway (3A01)
- Videolaryngoscopy (2B02)
- Human factors (1I03)

AIRWAY WORKSHOP

12 October 2016
The Teacher Building, Glasgow

2 November 2016
RCoA, London

8 February 2017
RCoA, London

6 April 2017
RCoA, London

£240 (£180 for RCoA registered trainees)
Organisers: Dr C Urquhart and Dr R Bhagrath

Overview
The airway workshop provides an opportunity to gain hands-on practice with airway equipment and teaching in core airway skills from experienced consultants. Appropriate for CT1 upwards, specialty doctors and consultants.

Workshops
- Fibreoptic handling skills (2A01)
- Supraglottic airways (1C02)
- Front of neck access (2B02)
- Awake fibreoptic intubation (2A01)
- Videolaryngoscopy (1C01, 1C02, 2A01)
- Guidelines (from NAP4 to 2016) (1C01, 1C02, 1I0S)

GASAGAIN (GIVING ANAESTHESIA SAFELY AGAIN) COURSE

16 November 2016
Bradford Royal Infirmary

26 April 2017
RCoA, London

£240
Organisers: Dr J Horn and Dr A Hunningher

Overview
This course provides strategies for managing a return to work. Simulation scenarios to refresh skills are enhanced with a series of short relevant lectures on the latest in the world of anaesthesia.

Workshops
- A&E
- Airway
- ICU
- Communication
- Paediatrics
- Obstetrics
- Theatre

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CPD STUDY DAYS
19-20 September 2016
RCoA, London
£355 (£270 for RCoA registered trainees)
Organiser: Dr P Groom and Dr M Goulden

DAY 1
- The paediatric difficult airway
  Dr P Murphy, Liverpool
- Perioperative care of children with chronic disease including diabetes mellitus
  Dr K Wilkinson, Norfolk and Norwich
- Paediatric day-case surgery
  Dr S Roberts, Liverpool
- Cardiomyopathy and anaesthesia
  Dr D O’Leary, Newcastle upon Tyne
- Management of massive obstetric haemorrhage
  Dr P Barclay, Liverpool
- Point of care coagulation testing
  Dr D Castillo, Chester
- Maintaining the momentum of major trauma care
  Miss H Jones, Liverpool
- The management of acute airway trauma
  Dr P Groom, Liverpool
- Acute pain management in the opioid-tolerant patient
  Dr M Goulden, Liverpool
- Cardiopulmonary exercise testing (CPET) interpretation
  Dr N Jain, Prescot
- Diabetes and adult surgical patients
  Dr J Prentis, Newcastle
- Strategies of handling the aftermath of an intraoperative death
  Dr R MacKinnon, Manchester

DAY 2
- Extracorporeal membrane oxygenation (ECMO) in adults
  Dr G Martinez, Cambridge
- Sepsis
  Dr S Rogers, Liverpool
- Principles of antibiotic therapy
  Dr J Sule, Cambridge
- Events medicine
  Dr J Cosgrove, Newcastle upon Tyne
- Principles of total intravenous anaesthesia (TIVA)
  Dr A Lumb, Leeds
- Enhanced recovery in thoracic surgery
  Dr G Martinez, Cambridge
- Obesity in pregnancy
  Dr P Faber, Aberdeen
- Chronic obstructive pulmonary disease (COPD) and anaesthesia
  Dr P Mulvey, Derby
- Ventilator-associated pneumonia (VAP): What we know and potential future developments
  Professor P Dark, Manchester
- Pre-operative anaemia
  Dr N Jones, Cambridge
- Oxygen targets and delivery in acute care
  Dr M Sharman, Manchester
- Perioperative acute kidney injury
  Dr J Prowle, London

CPD STUDY DAY
28 September 2016
The Waterfront Hall, Belfast
£200 (£150 for RCoA registered trainees)
Organiser: Dr B Darling

DAY
- Anaesthesia for bariatric surgery
  Dr C Nightingale, High Wycombe
- Interventional radiology in the management of strokes
  Dr P Keston, Edinburgh
- Role of Prehospital care in Trauma Management
  Dr K Goddard, Belfast
- Long term vascular access: insertion, removal and organisational issues
  Dr A Bodenham, Leeds
- AAGBI guidance on safe vascular access
  Dr A Bodenham, Leeds
- Fast track total knee arthroplasty
  Dr D Johnston, Belfast
- Analgesia for acute surgical pain
  Dr C Nightingale, High Wycombe
- How doctors cure crime
  Mr N Ross, Broadcaster
CPD STUDY DAY

UPDATE ON INTRA-OPERATIVE MONITORING

20 October 2016
RCoA, London
£200 (£150 for RCoA registered trainees)
Organisers: Dr R Verma and Professor R Mirakhur

- Standards of minimal monitoring during recovery and anaesthesia. Necessity or distraction?
- Automated anaesthesia record keeping systems. Should they be mandatory?
- Depth of anaesthesia monitoring. Should it be routine?
- Monitoring techniques for perioperative fluid management
- Intraoperative cardiac output monitoring
- Neuromuscular block monitoring: should it be part of minimal monitoring?
- Monitoring tissue perfusion: is it relevant?
- Intraoperative temperature monitoring

CPD STUDY DAY

4 November 2016
Mercure Hull Royal Hotel, Hull
£200 (£150 for RCoA registered trainees)
Organisers: Dr P Lanka, Dr A Hammond-Jones and Dr N Pai

- Traumatic brain injury (TBI) updates
  Dr M Wiles, Sheffield
- Atmospheric science and anaesthesia
  Dr T Pierce, Southampton
- Proactive care of older people undergoing surgery (POPS)
  Dr J Partridge, London
- Pre-oxygenation
  Dr I Wrench, Sheffield
- What’s new in bariatric anaesthesia?
  Dr E Shearer, Liverpool
- Enhanced recovery after surgery (ERAS) in obstetrics
  Dr I Wrench, Sheffield
- Patient blood management in surgery – an update
  Dr R Rao Baikady, London
- The role of NCAS and how to avoid getting into difficulty
  Dr A Budd, Herefordshire
- Current evidence in acute pain management
  Dr J Cashman, London
- Total intravenous anaesthesia (TIVA) competencies and challenging conditions
  Dr R Juneja, London

CPD STUDY DAY

ANAESTHESIA FOR ORTHOPAEDIC SURGERY

18 November 2016
RCoA, London
£200 (£150 for RCoA registered trainees)
Organisers: Dr R Verma and Dr N Narula

- Pushing the frontiers in spinal surgery
- Anaesthetic techniques for upper limb surgery / concepts and practicalities of day case regional anaesthesia
- Anaesthesia for shoulder surgeries
- Anaesthetic considerations for paediatric orthopaedic procedures
- Bone cement – peri-operative implications
- Management of blood loss in elective orthopaedic surgery
- Enhanced orthopaedic recovery
- Thromboprophylaxis and orthopaedic surgery

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WINTER SYMPOSIUM

24-25 November 2016
RCoA, London
£395 (£295 for RCoA registered trainees)
Organisers: Dr P Kumar and Dr J-P Lomas

DAY 1
SESSION 1: ASSOCIATION FOR CARDIOTHORACIC ANAESTHESIA AND CRITICAL CARE (ACTACC)
- There should be public disclosure of surgical mortality by an anaesthetist
  Dr N Fletcher, London
- No elective surgical patient should die on the operating table: ECMO-CPR
  Dr J Barker, Manchester
- Perioperative beta blockers - yes or no?
  Dr G Flood, Dublin

SESSION 2: NEUROANAESTHESIA SOCIETY OF GREAT BRITAIN AND IRELAND (NASGBI)
- Anaesthesia, bad for the brain?
  Dr J Dinsmore, London
- Collars in the coffin
  Dr M Wiles, Sheffield
- Dexmedetomidine for sedation outside ITU
  Dr J Sebastian, Salford

SESSION 3: BRITISH SOCIETY OF ORTHOPAEDIC ANAESTHETISTS (BSOA)
- Getting it right the first time: improving quality of care for all NHS patients
  Professor T Briggs, London
- The 21st Century Trauma
  Speaker to be confirmed
- Lower limb arthroplasty – key perioperative issues
  Dr A Carney, Nottingham

SESSION 4: AGE ANAESTHESIA ASSOCIATION (AAA)
- How do we fit present workforce to the aging population
  Ms A Babic-Illman, London
- Frailty
  Dr P Braude, London
- Dementia perioperative management
  Dr I Foo, Edinburgh
- SAS update and networking
  Dr K May, Oxfordshire

DAY 2
SESSION 5: REGIONAL ANAESTHESIA - UNITED KINGDOM (RA UK)
- Is RA worth it: does it affect outcome?
  Dr A MacFarlane, Glasgow
- Should peripheral nerve stimulation still be taught?
  Dr A Krol, London
- Are perineural catheters obsolete?
  Dr A Pawa, London

SESSION 6
KEYNOTE LECTURE
Dr N Chrimes, Australia

- MACINTOSH LECTURE
  Dr I Moppett, Nottingham
- Presentation of College awards
- President’s Commendation
  Dr G Pugh, Gwent

SESSION 7: TRAINING
- Basic transthoracic echo and lung ultrasound should be in the anaesthesia curriculum
  Dr N Morgan-Hughes, Sheffield
- Forty years on: training for better and for worse
  Dr A Skinner, Middlesbrough
- Dogma in obstetric anaesthesia
  Dr S Bricker, Wirral

SESSION 8: BRITISH PAIN SOCIETY (BPS)
- Chronic post-surgical pain (epidemiology)
  Dr J Bruce, Coventry
- Moving on from the epidemic of opioid misuse: rethinking the role of analgesics in pain management
  Dr C Stannard, Bristol
- Challenges in managing pain in the last days of life
  Professor S Ahmedzai, Sheffield

Follow @RCoA_Events | Find us on Facebook | Book online at: http://rcoa.it/booknow
CONTINUING PROFESSIONAL STUDY DAY

26 November 2016
RCoA, London
£240 (£180 for RCoA registered trainees)
Organiser: Dr B Shippey

Overview
The Continuing Professional Development Day is comprised of 12 lectures, running in 2 different streams. Delegates may choose 6 lectures, 1 from each stream.

<table>
<thead>
<tr>
<th>STREAM A</th>
<th>STREAM B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RECENT ADVANCES</strong></td>
<td><strong>CLINICAL PRACTICE 1</strong></td>
</tr>
<tr>
<td>1A Diabetes [2A03, 1A01, 1A02] Dr N Lev, Cambridge</td>
<td>1B Reducing transfusion in surgery associated with high blood loss [2A05] Dr A Nimmo, Edinburgh</td>
</tr>
<tr>
<td><strong>CLINICAL PRACTICE 2</strong></td>
<td><strong>CRITICAL INCIDENTS</strong></td>
</tr>
<tr>
<td>2A Prehabilitation [2A05] Dr G Danjoux, Middlesbrough</td>
<td>3A Apnoeic oxygenation [3A02, 2A01] Dr A Patel, London</td>
</tr>
<tr>
<td><strong>PERIOPERATIVE MEDICINE</strong></td>
<td><strong>PERIOPERATIVE MEDICINE</strong></td>
</tr>
<tr>
<td>3B Regional anaesthesia for abdominal procedures [2E01, 2G02] Professor G McLeod Dundee</td>
<td>4B Implantable devices [1A01, 2C04] Dr A Morley-Davies Shropshire</td>
</tr>
<tr>
<td><strong>CLINICAL PRACTICE 3</strong></td>
<td><strong>ANAESTHETISTS AS EDUCATORS:</strong> ADVANCED EDUCATIONAL SUPERVISION</td>
</tr>
<tr>
<td>4A Atmospheric science and anaesthesia [3I00, 1A01] Dr T Pierce, Southampton</td>
<td>5A Perioperative kidney injury [2A06, 1A01] Dr J Prowle, London</td>
</tr>
<tr>
<td><strong>UK PERIOPERATIVE MEDICINE CLINICAL TRIALS NETWORK AUTUMN MEETING</strong></td>
<td>5B Neurological disease [3F00, 2A03] Dr R Adapa, Cambridge</td>
</tr>
<tr>
<td>5A Neurovascular block [1A03, 1A02] Dr G Rodney, Dundee</td>
<td></td>
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<tr>
<td><strong>UK PERIOPERATIVE MEDICINE CLINICAL TRIALS NETWORK AUTUMN MEETING</strong></td>
<td></td>
</tr>
<tr>
<td>9 November 2016</td>
<td>9 November 2016</td>
</tr>
<tr>
<td>The Studio, Birmingham</td>
<td>Novotel Hotel, Sheffield</td>
</tr>
<tr>
<td>£45</td>
<td>£220</td>
</tr>
<tr>
<td>Organiser: Dr J Yeung</td>
<td>Organisers: Dr A Cooper and Dr T Dorman</td>
</tr>
</tbody>
</table>

This meeting is suitable for all clinicians, healthcare professionals and researchers who are currently active or want to be actively participating in clinical trials in perioperative medicine. UKPOMCTN meeting will combine investigator training and up to date information on current and future trials.

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JOINT RCoA/RSM MEETING: EMERGENCIES IN ANAESTHETIC PRACTICE

9 November 2016
RSM, London
£45
Please visit the RSM website for event fees.
Organiser: Dr W Sellers

CPD credits 6

This meeting is suitable for all clinicians, healthcare professionals and researchers who are currently active or want to be actively participating in clinical trials in perioperative medicine. UKPOMCTN meeting will combine investigator training and up to date information on current and future trials.

SESSION 1: LIFE-THREATENING
- Asthma
- Pre-hospital
- IM/IV drugs
- Enoximone – going Dutch
- Intensive care

SESSION 2: EPILEPSY
- Pre-hospital
- Emergency department
- Intensive care

SESSION 3: DIABETIC KETO-ACIDOSIS
- Pre-hospital
- Emergency department
- Intensive care

SESSION 4: SEPSIS
- Pre-hospital
- Emergency Department
- Intensive care
- Retrieval of the above

PATIENT SAFETY CONFERENCE

30 November 2016
Royal College of Physicians, Edinburgh
£215
Organiser: Dr J Pandit

CPD credits 5

The Safe Anaesthesia Liaison Group (SALG) are delighted to host the annual Patient Safety Conference in Edinburgh this year.

A single-day meeting which consists of lectures, each of which is followed by ample time for discussion. It is intended for doctors engaged in clinical anaesthesia, pain management and intensive care medicine (i.e. Consultants, Staff and Associate Specialist Grades or their overseas equivalent) who have a particular interest in improving patient safety.

We are delighted to announce that Dr Catherine Calderwood, Chief Medical Officer for Scotland, will open the conference. Experts will present up-to-date information on a wide range of patient safety related topics, including:

- The culture of safety, from ideal to real, Dr S Woodward, Sign up to Safety
- HALT: breaking down hierarchies in theatres, Dr S Fisher and Mr N Jones, Liverpool
- Preventing never events, Dr W Harrop-Griffiths, College Council member, London
- Human Factors, Dr M Langham, Brighton
- Implementing IT systems safely, Dr A Stavert-Dobson, Sheffield
- Implementing the neuraxial connector standard, Mr T O’Kelly, Aberdeen

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Appointment of Fellows to consultant and similar posts

The College congratulates the following Fellows on their consultant appointments:

**Dr I R Barker**  
Imperial College NHS Healthcare Trust

**Dr P K Battu**  
University Hospital Birmingham

**Dr J Cameron**  
Borders General Hospital, Melrose

**Dr O Daly**  
Royal Infirmary of Edinburgh

**Dr H Ellis**  
Sheffield Teaching Hospitals NHS Foundation Trust

**Dr A D Holder**  
Peterborough & Stamford Hospitals NHS Foundation Trust

**Dr E J Jackson**  
Lewisham and Greenwich NHS Trust

**Dr S Jeyanthan**  
University Hospital Birmingham

**Dr M Kayani**  
Frimley Park Hospital

**Dr L L M Li**  
Victoria Hospital, Kirkcaldy

**Dr Arun Nair**  
Derby Teaching Hospitals

**Dr J K Parsons**  
Raigmore Hospital

**Dr R Ramachandran**  
Doncaster Royal Infirmary

**Dr T L Samuels**  
Surrey and Sussex NHS Trust

**Dr D B Subramani**  
George Eliot Hospital

**Dr M P A Steynor**  
Derriford Hospital

Advertising in the Bulletin

The RCoA Bulletin is published bi-monthly and distributed to over 17,000 anaesthetists worldwide, the vast majority being in the UK. Advertisements for courses and meetings from anaesthetic societies, or those organisations that are of interest to anaesthetists, are accepted with prior approval of the Editor or Editorial Board. Advertisements must fit with the aims and aspirations of the RCoA and be related to anaesthesia, critical care and pain medicine.

Please contact bulletin@rcoa.ac.uk for separate advertising rates from commercial organisations.

The advertising rates below are valid up to and including the July 2017 issue:

- **Quarter page (portrait – 85 mm by 124 mm)**  
  £283.00 +VAT

- **Half page (portrait – 85 mm by 252 mm)**  
  £560.00 +VAT

- **Full page (175 mm by 252 mm)**  
  £900.00 +VAT

Please go to the website to complete the necessary Terms and Conditions before submitting your advert online which are available via the following link:  
www.rcoa.ac.uk/the-bulletin/advertising-deadlines

Deaths

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

**Dr William Cochrane**  
Wellington, New Zealand

**Dr Peter Morris**  
Cheshire

**Dr Julien Warshafsky**  
East Sussex

**Dr Jacqueline Dalton**  
Southport

**Dr Vaidialingam Jeevananthan**  
Milton Keynes

**Dr Joseph Warren**  
Ascot

**Dr Anis Baraka**  
Beirut, Lebanon

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.
Developing World Anaesthesia

3 October 2016
RCoA, London

£150
Organiser: Dr B Gupta

An intensive one day course covering the basics of anaesthetic practice for developing countries and resource poor environments. Suitable for all grades of anaesthetist.

- Introduction to draw over anaesthesia
- Practical use of Ketamine in the field
- Hands-on equipment sessions (draw over circuits, oxygen concentrators etc.)
- Obstetric anaesthesia
- Paediatric anaesthesia
- How to organise your time away and get it recognised
- Problem solving in the field
- Recent experience from the field

5th Anaesthesia CPD Matrix Updates

17th & 18th November 2016
Frimley Park Hospital

2 day course for Consultants and NCCGs addressing a diverse range of topics contained within the RCoA Matrix.

£75 : 10 CPD POINTS

Regional Anaesthesia, Ethical Decision-Making, Liver Disease, Perioperative Respiratory Complications, Obstetric Haematology, Communication, Patient Experience, Organ Donation, Reducing Risk, Human Factors, Bariatric Anaesthesia, Technology & Learning, DNAR, Palliative Surgery, PPMs & ICDs, Cancer Surgery, Diabetes

Contact elizabeth.comber@ffht.nhs.uk for more details, full programme or to book your place
Society for Intravenous Anaesthesia
Annual Scientific Meeting
24th and 25th November 2016

Holiday Inn Hotel (soon to be Crowne Plaza)
Stratford upon Avon, CV37 6YR
Visit the SIVA website for the latest information: www.siva.ac.uk/asm

Scientific programme includes:
TIVA in Clinical Practice
End Organ Protection
Pharmacogenomics, Post-op Analgesia in Chronic Pain, Hyperalgesia
CNS and Pain Monitoring
PK Variants in Pumps
The SIVA Debate - 1 Syringe, 1 Drug?

Registration fees:
Registration fees from £215 (£145 for trainees)
(No fees for trainees whose posters are accepted for presentation)
Accommodation £85 – Bed & Breakfast at the Holiday Inn Hotel
Free parking on site
See website for other transport options

Extended half day workshop for novices only - limited places available

Association for Cardiothoracic Anaesthesia & Critical Care
Autumn Education Meeting
Monday 7th and Tuesday 8th November 2016
SOAS, University of London, WC1H 0XG

Core Topics Include:
Thoracic Anaesthesia
Haematology for Anaesthetists
Cardiology for Anaesthetists
Heart Failure Treatment
Pre-optimisation
Cardiac Anaesthesia
Critical Care

Workshops to Include:
Basic ECHO including TTE
Advanced ECHO Quantification
One Heart
One Lung

CPD points applied for

For more information regarding this meeting, please visit www.acta.org.uk
If you have any queries please contact Faye Deakin on faye@eventmanagementdirect.co.uk or call Faye/Jane on 0114 245 5423
Annual London Peri-Operative Medicine Congress:

**EBPOM 2017**

4th, 5th & 6th July 2017

**Call for Abstracts**

We invite you to submit work for poster presentation. Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 7th April 2017.

Inclusion of up to 1 table and 1 figure is permitted. Abstract length should not exceed 400 words and should be submitted in 12pt Times Roman font.

£1000 in prizes. See website for full details.

All presenters, both poster and oral, must register for the conference to present their work.

To submit an abstract visit: www.ebpom.org/abstracts

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**Regional EBPOM 2016**

Newcastle

Hilton Gateshead

3rd November 2016

- Dr Chris Snowden, Newcastle (Chair)
- Dr Dan Conway, Manchester
- Dr Jagdeep Dhesi, London
- Prof Mike Grocott, Southampton
- Prof Eileen Kaner, Newcastle
- Dr Gary Minto, Plymouth
- Prof Monty Mythen, London
- Mr Rob Thompson, RCOA

**Booking Open** - use code BJABS10 for a 10% discount

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**15th Peri-Operative CPET Course**

Montague Hotel, London

28th and 29th November, 2016

Cardiopulmonary Exercise Testing For Pre-operative Assessment Course

- Only 40 delegate places per course
- Faculty to Delegate ratio 1:4
- Lectures, small group tutorials and workshops
- Underlying Physiology
- Test Interpretation
- Respiratory and Cardiac abnormalities
- Testing Practicities
- Setting up a new service
THE MSA SAQ WRITERS CLUB

The Writers Club has seen more than 500+ trainees through the SAQ Papers with a successful Pass Rate for those who have kept to the necessary disciplines. But many trainees apply far too close to the examination to derive anything like the full benefit from Membership. That Full Benefit includes Free Admission to the SAQ Weekend Courses, the Acquisition of a large and useful Collection of Answer Sheets and a Valuable Motivation towards Sustained Revision.

Membership Fee: A Single Payment of £400
Members are entitled to all benefits until successful in the SAQ Paper
Attendance to the SAQ Weekend Course – Free of Charge
Writers Club Motto: ’Within the Discipline, Lies the Reward’

Candidates are urged to
Join between now and October for the Spring 2017 Examination to reap maximum benefit
Enquiries to: writersclub.msa@gmail.com

Courses for the Royal College of Anaesthetists Examinations

<table>
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<tr>
<th>Courses</th>
<th>Dates 2016/2017</th>
<th>Capacity</th>
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<tr>
<td>Primary SBA/MCQ</td>
<td>14 – 20 October</td>
<td>January 2017</td>
</tr>
<tr>
<td>Primary OSCE Weekend</td>
<td>7 – 9 October</td>
<td>December 2016</td>
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<tr>
<td>Primary Viva Weekend</td>
<td>21 – 23 October</td>
<td>January 2017</td>
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<tr>
<td>Primary SBC/Orals</td>
<td>28 October – 4 November</td>
<td>January 2017</td>
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<tr>
<td>Final SBA/MCQ</td>
<td>February 2017</td>
<td>August 2017</td>
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<tr>
<td>Final SAQ Weekend</td>
<td>February 2017</td>
<td>August 2017</td>
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<tr>
<td>Final Written ‘Booker’</td>
<td>February 2017</td>
<td>August 2017</td>
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<tr>
<td>Final Viva Revision</td>
<td>5 – 10 November</td>
<td>May 2017</td>
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<tr>
<td>Final Viva Weekend</td>
<td>25 – 27 November</td>
<td>June 2017</td>
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</tbody>
</table>

“I was very undecided initially about coming to Mersey. In the end, I decided 8 days of intense revision could only help. I also had reservations about the timing of the course (which finished on Friday 13 May, followed by exam week from Monday 16 May), but as it turns out the timing was spot on. By Thursday at the course, I was ready to take the exam (I had gone in feeling underprepared) and found my wait until the following Thursday too long!

It goes without saying that the hours need to be put in, the homework needs to be completed and every opportunity needs to be taken for practice. The course then helps put it all together and gives that final boost of confidence and technique. I went into the course feeling (CONVINCED!) I would fail, and left feeling like I could give the exam a good shot!

Mersey gave me the confidence to help me pass, the tips to stop me freaking out, and filled in gaps in my knowledge that I needed. I am definitely going to come back to Mersey for finals!”

– Primary OSCE/SOE Candidate May 2016

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