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Articles for submission, together with any declaration of interest, should be sent to the Bulletin Editor via email to: bulletin@rcoa.ac.uk. All contributions will receive an acknowledgement and the Editor reserves the right to edit articles for reasons of space or clarity.

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From the Editor

Welcome to the September issue of the Bulletin, which is my last as editor. It is hard for me to believe that I have now completed a three year term, my first issue having been in November 2008. From this November, Ann Thornberry will take the reins, and I am sure that she will bring her own style and strategy to future issues. I think that the post of editor has given me as much pleasure as anything I have done in my professional career. I have been privileged to have led a great team, and most of all to have worked with Mandie Kelly and Edwina Jones, who are the stalwarts of production. What you see is down to their skill in design and layout, and their ability never ceases to amaze me.

It is worth reflecting where the Bulletin is currently, in the grand scheme of College and professional life. The last three years have seen a number of important changes to both the style and format, as well as the contents of each issue. We have continued the excellent work started by Keith Myerson in modernising the style and layout. We have also made changes to the content, with many more articles being commissioned, rather than placing reliance upon unsolicited submissions. This allows themed issues, which seem to have the approval of most. It also means that those articles which are submitted have to be of higher quality to get published. Many don’t make it, and the editorial board is kept busy deciding which to accept and which to reject. We now try to plan issues well in advance and, as I write this, we have a rough idea of how future issues will look until July 2012 (which probably will focus on the Olympics and anaesthesia). It has grown in size too, and each issue contains an extra 16 pages compared with three years ago. One downside, however, is that we seem to have killed off the correspondence section unintentionally. Please consider writing letters in response to articles published. These will be posted on the College website, with some selected for publication in the subsequent issue. Overall, I hope that the Bulletin is in fine fettle, and able to go from strength to strength.

This issue has day surgery as its theme, with an editorial by Professor Monty Mythen, who is the national lead for the enhanced recovery programme. There are no less than six articles on various aspects of day surgery, ranging from pre-assessment and selection criteria, to spinal anaesthesia.

Other topics include preparation for the initial test of competency by Dr Mukherjee and one of her novice trainees, latest news about national recruitment from Dr Marks, and advice from Dr Thornberry about writing references for those applying for specialist registration through the certificate of eligibility route. Dr Henderson tells us everything that we think that we know already about study leave for trainees, but probably don’t, whilst Dr Cook looks at plans for the next national audit project, NAP5. Charlie McLaughlan, Director of Professional Standards, summarises the results of the workforce survey recently carried out by the department. A more complete breakdown of the returned data can be accessed on the College website.

So that about wraps it up from me. Many thanks to all who have helped put together the issues, planned the content and, most of all, written the material. I will certainly miss my involvement with the Bulletin, and being ‘kept in order’ by Mandie and Edwina, but I am sure that the President will soon fill the hole that it leaves with many more varied and interesting tasks!
The Joint Committee on Good Practice (JCGP) is a forum where the AAGBI and the RCoA meet with the National Clinical Assessment Service (NCAS) and the GMC, to ‘monitor the health of anaesthesia practice’. The Presidents of the Association and the College chair the committee and alternate every two years. Much good work has come from this collaboration. Most importantly, in 1998, the committee produced the first edition of ‘Good Practice: A guide for Departments of Anaesthesia, Critical Care and Pain Management’ (the third edition published in 2006). Obviously, with the introduction of revalidation, and the appearance of the Faculty of Pain Medicine and the intercollegiate Faculty of Intensive Care Medicine, this document requires a significant re-write, and this is now in hand.

What has become apparent is that areas of our specialty need a forum to discuss matters in general, and not those just related to standards of practice. To that end, Iain Wilson, in his formal role as President of the AAGBI, recently hosted a successful dinner at 21 Portland Place to discuss matters of mutual interest to the anaesthesia community in general. I hope that more of the specialty societies and associations will be able to join the next dinner. We discussed a number of areas of common interest: neuraxial connectors, capnography, sedation guidelines, ACCEA, consultant career structure, SPAs, professional leave, CPD and the role of practitioners. However, it seems to me that in discussion with the AAGBI Welfare Committee and other interested parties, the JCGP may change to become a wider and more representative forum. Watch this space.

Health Committee
Many of you will have seen the Commons Health Committee report on the accountability hearings with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC), published on 26 July 2011. In essence, the Rt Hon Stephen Dorrell continues his campaign of pressurising the GMC – particularly with regard to revalidation and the language skills of doctors from the European Economic Area (EEA)– but also recognises that health care assistants need formal regulation. It remains a mystery to me as to why the Health Professions Council cannot take on the task of regulating physicians assistants (anaesthesia) and critical care practitioners. I will continue to press Health Education England (HEE) to address this anomaly.

There is also a clear signal in the report that doctors, as professionals, must act upon any concerns they have regarding any diminution in standards of care; fine words, indeed.

Workforce planning
Data collection for the College’s third workforce census is now complete and, remarkably, there was another 100% response from departments, who were given eight core questions to consider. However, as always, the last few forms took an inordinate amount of time and effort to obtain. The Centre for Workforce Intelligence (CfWI) rates our College highly for the completeness of its data, and we need to maintain that reputation. Hence, my thanks go to all those departments of anaesthesia that provided data quickly but, paradoxically, also to those departments that struggled to respond on time. I appreciate that it is not always easy to provide such data in some hospitals.

My thanks go also to Charlie McLaughlan and his team in the Professional Standards Directorate at the College for their professionalism and perseverance in obtaining this data. The initial results provide...

The Faculty of ICM is also conducting detailed surveys of the actual and perceived workforce needed to support critical care services and we are collaborating closely with them.

In England, although it is important to link with the devolved nations, the immediate need is to work with HEE, as it gains an overview of the developing future workforce, and its requirements for education and training. HEE will allocate the funding for this (nearly £5 billion), and will include not only medical and dental training, but also nursing and allied health professionals. It seems to me that the expectation of many is that doctors will receive less of this money for their continued professional development, and that more will go to developing other parts of the workforce required by hospitals.

The Confidential Enquiries
Despite enormous pressure from the profession, serious concerns remain about the prolonged death of the National Patient Safety Agency (NPSA), especially as to where its various responsibilities will eventually end up. However, following the publication of Dr Sheila Shribman’s Report on 27 July 2011 (www.nrls.npsa.nhs.uk/resources?entryid45=131072), at least we now know that the Confidential Enquiry into Maternal Death (CEMD) will continue, with a new provider to be in place by April 2012. We will have to wait and see how the existing network of regional and central assessors will be utilised, if at all. Steve Yentis provides further commentary on the Obstetric Anaesthetists’ Association website at www.oaa-anaes.ac.uk/news-list.asp.

Dr Shribman’s recommendations are likely to be far-reaching, and they will undoubtedly influence the structure of future national audits. The immediate future of NCEPOD seems assured, having been successful earlier this year in the tendering process although, like the CEMD, they are now within the clinical outcomes review programme, and part of the Healthcare Quality Improvement Partnership (HQUIP).

The Practitioner Health Programme (PHP)
In 2008, the Department of Health funded a two-year pilot in London, of a confidential and free service for doctors and dentists with a mental health or addiction concern, or a physical health concern that was potentially affecting their performance. The PHP complemented existing NHS GPs, occupational health, and specialist services. The pilot demonstrated clearly the need for the service, and that a swift, safe return to work can lead to significant savings overall. The compelling evidence presented during the evaluation of the pilot clearly demonstrated that the PHP is a crucial service, and that its value to the NHS as a whole cannot be underestimated. A letter supporting its continuation and development was sent to chief executives and medical directors explaining these benefits. The signatures were the Royal College of Anaesthetists, the Academy of Medical Royal Colleges, the Medical Protection Society, the Medical Defence Union, the British Medical Association, the Medical and Dental Defence Union of Scotland, and the National Clinical Assessment Service. I ask those of you who have influence within your hospital and with commissioners to support this valuable initiative throughout the UK.

NICE Fellows and Scholars
In mid-September, there are plans for the National Institute for Health and Clinical Excellence to seek applicants to its fellows and scholars programme – see their website for details. I alluded to this earlier this year in the May issue of the Bulletin. Those trainees and consultants who wish to develop an interest in leadership and management are encouraged to apply.

The Medical Futures Innovation Awards
By invitation, I attended the exhibition of this prestigious meeting in Old Billingsgate, London, on 6 June 2011. There were many interesting projects on view, including novel nitric oxide generating technology developed by the group led by Charles Hinds at Barts and The London NHS Trust. At the awards dinner later that night, with some seriously risqué hosting from Rory Bremner, Charles and his team were delighted to be the overall winners of The Respiratory Innovation Awards 2011; many congratulations to them (see www.medicalfutures.co.uk/awards_about.php?category=2011Winners).

For the last two years, I have been privileged to serve as one of two national clinical leads for the Department of Health’s Enhanced Recovery Partnership Programme, alongside Mr Alan Horgan, a surgeon from Newcastle.

The concept of enhanced recovery (ER) has been familiar to many of us for nearly two decades. The lectures and papers from Professor Henrik Kehlet, a surgeon from Denmark, used to leave me feeling sceptical, frustrated or inadequate. It was only when a successful ER programme was started at University College London Hospitals, under the stewardship of a recently arrived surgical colleague Mr Al Windsor, that I started to believe that it was possible. Now, after two years leading the national programme, I am completely convinced that the future of perioperative care lies in enhanced recovery being the norm, rather than boutique care.

As detailed in a series of articles in this issue of the Bulletin, enhanced recovery after surgery (or fast track) is a bundle of care intended to allow patients to recover more quickly from major surgery and thus leave hospital earlier. It is not about ‘kicking patients out of hospital’ too early. Enhanced recovery should improve outcome, shorten hospital stay, and thus reduce the overall cost of care: a win-win-win scenario. Hence the Department of Health’s enthusiasm for a national programme, as it strives for ever greater quality and productivity.

The Enhanced Recovery Partnership Programme is a multi-modal bundle of best evidence based care delivered by a multi-professional team. Core elements are interventions that have been tested in single centre trials, such as avoidance of bowel preparation and nasogastric tubes, goal directed fluid therapy, immediate postoperative feeding, and early mobilisation facilitated by short acting anaesthetic agents and regional analgesia. However, ER is evolving, and will continue to do so as novel techniques and therapies emerge.

The Department of Health’s programme for England ran for two years from Spring 2009 to 2011. The programme utilized a change management strategy that relied on sharing best practice, building consensus, and thereby driving the spread and adoption of ideas with feedback of outcomes, and bench marking against peers. Each participating NHS trust identified local champions (including doctors, nurses, allied health professionals and managers) who drove the process. The core elements of our national programme were agreed in a series of consensus meetings, and were based upon best practice in a number of NHS trusts. The conclusions and guidance on effecting change were published in an implementation guide, along with a summary of published evidence that can be found at www.improvement.nhs.uk/enhancedrecovery.

Anaesthesia, pain management, perioperative medicine, and intensive care are right at the heart of ER. Fellows of the Royal College of Anaesthetists were notable leaders in all local and regional programmes, and the national leadership team included Kerri Jones, Martin Kuper and Mike Swart, as well as myself. By February 2011, more than 85% of NHS trusts were reported to have an enhanced recovery programme at some stage of development. Nationally, length of stay...
has fallen, producing financial savings to the NHS. The most recent figures suggest that this improvement has been maintained, and adoption by new centres continues. However, the national ER programme was only a kick-start. The conclusion of the two-year programme heralds the beginning of a fundamental change in the care of patients undergoing surgery in the UK, not the end. It is accepted that a local ER programme can take up to five years to mature, and even be a springboard to further improvements year on year as novel techniques and therapies emerge.

The overall goal is zero tolerance of postoperative harm, and the bar heightens each year as we live longer and have greater expectations, despite a growing portfolio of co-morbidities and poly-pharmacy. Some of the main challenges for continued development of ER in the NHS are:

➤ Improved preoperative assessment, commencing early enough to allow intervention where necessary (in other words, starting at the time of GP referral).

➤ Truly informed consent and shared decision making.

➤ Ready adoption of novel techniques shown to provide benefit (for instance oesophageal Doppler to guide perioperative fluid management, as recently approved by the National Institute for Health and Clinical Excellence (NICE).)

➤ Measurement and sharing of high quality outcome data with national and international benchmarking.

➤ Robust discharge planning, and more places for patients to go when discharge straight home is not possible.

The first four of these are within the remit and gift of anaesthetists and perioperative physicians. Much work has already been done on ‘fitness for referral’ and truly informed consent. The foundation of the NIAA Health Services Research Centre gives us real hope that we can achieve high quality data and benchmarking, but we must all engage. I wait with baited breath to see how the NICE guidance on Doppler plays out. Will the broader anaesthetic community seize the day and make individualised goal directed fluid management a standard of care? Or will we argue amongst ourselves about the nuances of individual studies, diverting attention from the real issue: that modern perioperative care is challenging, and a key component of quality outcome from surgery?

References
2 www.improvement.nhs.uk/enhancedrecovery/.
Trainee study leave: the real cost

How much of your own money have you spent on study leave in the last 12 months? Ever wondered how much this will amount to by the time you finish your training?

Dr A P Jennings
Specialty Registrar in Anaesthesia, Queen Elizabeth Hospital, Birmingham

Dr K Henderson
Specialty Registrar in Anaesthesia, Worcestershire Royal Hospital

Dr A Malins
Consultant in Anaesthesia and Head of School, West Midlands Deanery

Study leave is granted for postgraduate purposes approved by the employing authority, and includes study (usually, but not exclusively or necessarily, on a course), research, teaching, examining or taking examinations, visiting clinics and attending professional conferences. The NHS is under financial pressure; as a consequence, efficiency and cost savings are being sought. Study leave budgets may come under increasing scrutiny in the future. At the same time, the costs of being a doctor in training are escalating, making the financial support and leave of absence provided by study leave ever more vital.

However, we suspected from personal experience that doctors also spend much of their own money on professional development as they move up the career ladder towards an ultimate substantive appointment. These monies may be spent on examinations, courses and attending conferences. We have not found any published data that have previously evaluated the study behaviours (both in terms of time and cost) of anaesthetic trainees, or their utilisation of study leave.

The West Midlands Deanery consists of three schools of anaesthesia (Birmingham, Stoke, and Coventry and Warwick) with a total of 240 anaesthetic trainees. We conducted a survey enquiring about the use of study leave during the training year August 2009 to August 2010.

Our aim was to obtain evidence to support the continued resource allocation made to postgraduate study leave. The survey was intended to:

➤ assess trainees’ understanding of study leave allowance and budget
➤ ascertain the pattern of utilisation of this study leave
➤ identify the financial cost associated with training.

One hundred and sixty three trainees completed the survey, giving a 68% response rate. These responses were evenly distributed amongst the training grades CT1 to ST7.

Financial allowance
Many trainees were unaware of their study leave entitlements. Only 56% knew that the study leave allowance in the West Midlands is £600 per annum (or £50 per month). Over a seven-year training period, this amounts to a total of £4,200.

Time allowance
Forty percent of our responders were unaware of the number of study leave days they were entitled to. In the West Midlands, this currently stands at 30 days of paid study leave per annum, with 15 days allocated to compulsory regional teaching sessions for pre-fellowship trainees. This is a national figure, as stated in the NHS Terms and Conditions of Service document for hospital medical staff. On average, trainees used 13.4 days from their allocated study leave allowance per year.

Each trainee used an average of 2.6 days of annual leave or weekend days to attend study commitments. Many respondents commented that they used scheduled days off and pre- or post-night days to attend courses and study days. Unfortunately, the survey was not designed to assess this further. They also commented that many courses now have a substantial pre-course online component which they completed in their own time.

Trainees voiced concerns that they may not be granted study leave due to service commitments. They were also mindful of the fact that, if they used all their study leave days, insufficient time might be spent in the clinical setting, and that, therefore, they might be unable to complete their required units of training.

Distribution of study leave utilisation
Analysis of the distribution of study leave days taken showed exam preparation (18%), private study (15%), professional development courses (11.7%), and resuscitation courses (11%) to be the most prevalent (Figure 1).

Alongside this, analysis of the distribution of study leave expense showed resuscitation courses (18.8%),
examination fees (17%), and examination preparation courses (13%) to be the most common areas of expenditure (Figure 1).

**Personal expenditure**
The average study cost for a trainee over seven years of specialist training amounted to £10,617.24. The average amount of study leave claimed was £468.69/year (or £3,280.84/seven years). This leaves an average personal expense of £7,336.40 over seven years.

Hence, on average, each trainee spent £1,048 of their own money on study leave in the year August 2009–2010. The most expensive year of training was ST7. This is likely to reflect the intense professional development in the final training year, as areas of specialist interest are refined (Figure 2). Trainees commented that they felt that it was essential to spend this extra money to have any chance of securing a consultant post.

More than £300 was spent on study leave related expenses per trainee, mainly on travel and accommodation. However, only 30% of trainees claim this back due to a lack of remaining budget and the complexity of the claims process.

Despite this huge personal contribution, only 68% of trainees claimed their entire study budget, leaving on average £132/year per trainee unspent. The explanation is multifactorial. Utilisation of the study leave budget often has restrictions placed upon it. In the West Midlands it is expected that, where possible, trainees will attend courses within the deanery. Subsistence and travel expenditure is usually excluded. Applications must be prospective and have the support of the College and clinical tutors. Examination fees are not funded, and the use of study leave budgets to attend examination crammer courses is not looked upon favourably. The £600 budget is divided between training posts. Thus, if a trainee rotates to a different hospital after six months, they will have a £300 budget allocated per hospital. A pro rata allocation of £150 is allocated on the few occasions when the trainee undertakes a three-month specialist training module, and this cannot be carried over.

The study leave budget is allocated on an annual basis, and cannot be carried over if it is underused. The nature of training dictates that there are periods of high demand for study leave followed by relative lulls. Unfortunately, at present, the system does not accommodate for this.

**Budget calculation**
In light of these findings we estimated the minimum average study costs over seven years of specialist training. This enabled us to determine if the £4,200 allowance was appropriate for current training needs.

The main sources of expenditure are as follows.

**Royal College examination fees³**

<table>
<thead>
<tr>
<th>Course</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary MCQ</td>
<td>£295</td>
</tr>
<tr>
<td>Primary SOE/OSCE</td>
<td>£535</td>
</tr>
<tr>
<td>Final SAQ</td>
<td>£425</td>
</tr>
<tr>
<td>Final SOE</td>
<td>£510</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£1,765</strong></td>
</tr>
</tbody>
</table>

**Resuscitation courses⁴**

<table>
<thead>
<tr>
<th>Course</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Life Support</td>
<td>~£350</td>
</tr>
<tr>
<td>European Paediatric Life Support</td>
<td>~£400</td>
</tr>
<tr>
<td>Advanced Paediatric Life Support</td>
<td>~£550</td>
</tr>
<tr>
<td>Advanced Trauma Life Support</td>
<td>~£550</td>
</tr>
<tr>
<td>ALS+EPLS+ATLS</td>
<td>=</td>
</tr>
<tr>
<td>Recertification (ALS+EPLS+ATLS)</td>
<td>=</td>
</tr>
</tbody>
</table>

*(Course fees vary according to location, but were correct as of June 2011)*

The exam fees only apply if all parts are passed on the first attempt, and does not include travel, accommodation, books or courses. Examination fees are not covered by study leave budget.

Most trainees will attend resuscitation courses prior to applying for higher specialist training. They are valid for four years, which means that at least one recertification is required to ensure continued accreditation to the time of award of CCT for each course. Many trainees are unaware of the option to recertify which attracts a reduced course fee (£100–200 each), and choose to attend the whole course a second time, often in order to obtain ‘instructor potential’ recognition. To sit ALS, EPLS and ATLS and recertify in each once will cost approximately £1,700.

**Postgraduate professional development courses**
West Midlands’ anaesthetic trainees are required to complete eight professional development courses (or a national equivalent). Example topics include leadership, medical education and research. Each course costs £60 for one day. These deanery approved courses may generate a surplus which is used to fund a number of annual bursaries. Applications, when successful, support
registration, and presentations at national and international specialist meetings. There is also a requirement to complete a management course at a minimum cost of £400 during the last two years of training.

**Total: 8 x £60 + £400 = £880**

**Overall minimum seven-year expenditure**

<table>
<thead>
<tr>
<th>Cost Item</th>
<th>Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam fees</td>
<td>£1,765</td>
</tr>
<tr>
<td>Resuscitation courses (with recert)</td>
<td>£1,800</td>
</tr>
<tr>
<td>Professional development courses</td>
<td>£880</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>£4,445</strong></td>
</tr>
</tbody>
</table>

Examinations cannot be claimed from study leave monies in the West Midlands. If the entire cost of resuscitation and professional development courses is claimed from the study leave budget, £1,520 would remain (or £220/year of specialist training). This figure is insufficient to cover all additional professional development activities necessary to craft a high quality curriculum vitae. For example, many national conferences cost in excess of £400. This shortfall would have to be paid for from trainee’s personal funds.

**Conclusions**

This survey suggests the study leave allowance in days is sufficient. Moreover, few trainees use the full allocation. Conversely the financial study leave budget seems to be inadequate, and does not cover much of the study activity of trainees. Restrictions exist which can make it difficult to claim the full study budget, compounding the problem. Competition for consultant jobs is increasing, and more money is being spent on professional development by trainees in order to maximise the curriculum vitae. Our survey suggests that the current average personal spend by a trainee is £7,000. This expense can
In conclusion, we have managed to quantify the study leave behaviour of anaesthetic trainees in our region. It seems unlikely that the study leave budget will be increased in the current climate, but it should be vigorously protected because it is already arguably insufficient.

References


A trainee’s perspective in attaining the Initial Assessment of Competency (IAC)

Dr J Wilson
CT1 Anaesthetic Trainee, Medway NHS Foundation Trust, Kent, Surrey and Sussex Deanery

I had decided on a career in anaesthetics a couple of years before eventually applying, and started my CT1 post at Medway Hospital in Kent, in August 2010.

Stepping up from a foundation programme to a new specialty was a daunting prospect, and I was aware that the level of performance expected would be considerably higher. Even so, I was looking forward to taking on more responsibility, and experiencing a wide variety of challenging situations. During the induction process for new trainees, we were told that we would have to pass the Initial Assessment of Competency (IAC) before commencing on-call duties. Medway Anaesthetics Department had found that previous trainees achieved their IAC from between six and eight weeks and, therefore, wanted us to aim for this earlier IAC completion also. The aim was to help us to start on-calls earlier, therefore giving us greater opportunity to gain experience.

Looking at the curriculum, I found it difficult to know where to start gaining the essential knowledge that I would need for my first on-call. Talking to the CT2 trainees, I was given a list of textbooks and other useful resources such as the Royal College’s e-Learning Anaesthesia website.

To assist focusing on the knowledge required, one of the consultants at Medway has developed a booklet that covers the information for the initial competencies and, more importantly, the extra practical competencies required when starting an on-call commitment. These include, for example, knowledge of the specialised equipment one is required to understand and operate in the night, such as epidural pumps.

The booklet is set out clearly under various subjects headings, including ‘Drugs’ and ‘Equipment’. Within each subject theme, there are related topics such as ‘Induction agents’ and ‘Antiemetics’. There are two signature columns next to each individual topic, the first column is signed following initial discussion of the relevant topic; and the second column is signed once a verbal assessment of that topic has been completed. This process helps to consolidate the information, and proved useful in following the progress on each individual area, and to ascertain where more attention was required.

The booklet also has a practical page where insertion of 50 ETTs and LMAs can be signed off, and this allowed my supervisor to see how many airway devices I had managed, as well as giving an indication of how prepared I was for starting my on-calls. It was also a useful page for me personally, because reviewing it gave me more confidence that I would be able to assess and manage airway problems and intubations when on-call, and to know when to call for help if needed.

The booklet layout is straightforward, and topics easily follow on from one another. Each topic took about 30 minutes to complete, which meant that I was able to read a few topics a night and discuss them the following day. Within the first month, I had covered the booklet and was getting to grips with giving the anaesthetic, including airway management. It was a very steep learning curve, but was made much easier with the booklet directing me to the essential information.

I was assessed on the topics learned between four and six weeks from starting, and was able to incorporate the IAC assessments into the topic assessments, therefore avoiding a doubling of the number of signatures needed. I shadowed a CT2 trainee the weekend before I started my on-calls which was very helpful, and that gave me more of an idea of what to expect. Even though it was still daunting to start on-call commitments after just six weeks, I did feel well prepared. Another important factor in engendering confidence was the good senior cover.

On reflection, ten months later, I think this was a very good way of learning the essential information and preparing for commencement of the on-call commitment. It has also been very useful when revising for the Primary examination MCQ, because it ensured that I understood the topics well, and therefore could remember them better than if I had just read them through for the first time.

I would recommend this booklet for new CT1 trainees starting in August.
Colleague and patient feedback for revalidation

Dr R Moonesinghe
Council Member and Chair, Working Group on Colleague and Patient Feedback

Dr A Tomlinson
Senior Vice-President and RCoA Revalidation Lead

Mr D Liu
RCoA Revalidation Project Manager

The GMC has identified a number of areas where ‘core supporting information’ should be provided during appraisal, to demonstrate that a doctor is keeping up to date and that their practice is of sufficient standard to be able to revalidate. An important area is ‘feedback on your practice’, which requires both patients and colleagues to provide their views on the doctor’s professional performance. The College convened a working group to evaluate the available methods for obtaining such feedback, and provide guidance for anaesthetists to help them achieve this requirement.

Colleague feedback
Many anaesthetists already participate in colleague feedback exercises (also known as multi-source feedback or MSF) as part of their professional development and appraisal; indeed, it is a requirement for trainees in anaesthesia. The GMC and a number of commercial organisations provide online resources allowing doctors to select and invite colleagues to give confidential feedback on their practice. We believe that over 70% of NHS trusts have a contract with a commercial MSF provider currently. These systems provide the opportunity to give ‘free text’ comments, as well as the requirement to answer specific questions, the responses to which are benchmarked against national averages for colleagues of the same grade and specialty. Discussions with providers of colleague feedback resources and anaesthetists have led the working group to conclude that the available GMC or commercially provided options for completing MSF are sufficient for our specialty to fulfil this requirement of the revalidation agenda. A key GMC requirement, which the College endorses, is the use of a feedback tool which has been piloted and validated and in which the questions map to the GMC’s Good Medical Practice guidance. Thus, simply creating an online survey, which can be used within a department or trust, will not be sufficient to fulfil the revalidation agenda. A robust and validated quality assurance process must be undertaken on any new colleague feedback tool in order to meet the GMC’s requirements.

We have considered the possibility of developing a specialty specific colleague feedback tool for anaesthetists, but concluded that the generic questionnaires are ‘fit for our purpose’. However, we have provided guidance specific to anaesthesia, critical care and pain medicine specialists, about the number and types of colleagues who should be invited to respond. These include trainees, managerial staff, allied health professionals, and consultant colleagues from other specialties. We hope that this guidance will not be viewed as ‘overly prescriptive’, rather that it will provide helpful assistance for anaesthetists in complying with this aspect of the process. Another key recommendation is the necessity for the results of colleague feedback to be delivered to doctors by an individual who has been trained in the process. Such training is available from commercial providers, and we hope that it will also be available from the College from 2012. Furthermore, there should be a robust system for reporting the results of such feedback to an individual’s appraiser in every department, including mechanisms that ensure the exercise is repeated within a five year revalidation cycle if the results are deemed unsatisfactory.

Patient feedback
Obtaining reliable and valid patient feedback about communication skills poses a much greater challenge for anaesthetists. The GMC, commercial providers and anaesthetists all identified a number of issues that were considered by our working party. These include the methodology for selecting patients who might provide such feedback and the timing and method of distribution and collection of the questionnaires. Furthermore, questions about whether ‘generic’ patient feedback tools are appropriate for use in all the patient sub-groups we are responsible for, and the necessity for benchmarking anaesthetists against each other rather than against other medical professionals, need to be considered. Several logistical problems have to be overcome.

Firstly, it is intuitive to believe that, in order for patient feedback to be un-biased, a neutral third party should be responsible for selecting which patients should be invited to participate. This is a relatively straightforward process in outpatient clinics (for example, a receptionist could randomly select patients to complete the forms), but perhaps more challenging in the perioperative period, when patients cared for by a particular anaesthetist may be scattered across the hospital.

Secondly, at what point in the hospital stay should patients be asked to complete the feedback forms? The GMC’s guidance
indicates that patients should be given feedback forms as soon as possible after a consultation, but this may not be suitable in anaesthetics, a view shared by the RCoA’s Patient Liaison Group. Immediately after a preoperative consultation, the patient may be too anxious about the forthcoming surgery to want to participate; immediately after surgery they may not have recovered sufficiently to be able to comply, whilst after discharge the return rates for postal questionnaires are known to be poor. Furthermore, some patients may have forgotten the anaesthetist, and their specific role in their perioperative experience. Linked to this, there is a risk that anaesthetists may be held to account for factors affecting the patient’s experience that are beyond their control such as delays in operation start times and problems in the healthcare environment. Such factors may lead to unfair bias against the anaesthetist. Thirdly, our specialty provides care for a number of specialist patient groups, including the critically ill, obstetric and paediatric patients. It is clear that obtaining patient feedback from each of these sub-groups poses different challenges such that they may require different questionnaires; consequently the results of feedback from these types of patients may not be directly comparable against each other. Finally, the information given by commercial providers confirmed the practical difficulties which anaesthetists experience in administering patient feedback questionnaires: only a small percentage of anaesthetists who currently participate in MSF also submit patient feedback questionnaires for evaluation.

Despite these challenges, it is important for our profession to provide patient feedback where available and possible. The GMC has provided the ‘get out clause’ for specialties that do not have direct patient contact (histopathology being an obvious example), allowing them not to recommend to their doctors the mandatory participation in patient feedback processes. However, despite possible public perception to the contrary, we know that anaesthetists are excellent communicators generally, and that they have to gain the patient’s trust in a time-limited environment, and often at a time of great stress to the patient. Therefore, we believe that our specialty should be willing participants in the patient feedback process. The RCoA’s recommendations on patient feedback include guidance on the use of specific questions about the ‘patient experience’. These are provided by the annual NHS Inpatient Survey, and may be used to provide a summary representation of the patients’ views on the whole department, which can then be used by individual anaesthetists if other feedback is not possible. We also recommend that all anaesthetists who have outpatient responsibilities (for instance, in preoperative assessment, pain, or sleep clinics) should use a GMC or commercially provided and validated patient feedback tool to assess their communication skills. However, we have stopped short of mandating this as a part of the revalidation process for anaesthetists whose practice is entirely ‘surgical’ whilst we undertake further work in addressing the challenges outlined.

Work in progress
We are aware that obtaining patient and colleague feedback will take time and resources for individual anaesthetists and their trusts and, therefore, whilst we are required to engage with these processes, we are also keen to evaluate a number of associated factors. Although there is a large body of work evaluating patient and colleague feedback in practice, the evidence available offers few answers about the benefits of participation with regard to professional development. A systematic review of the use of ‘workplace based assessments’ found that there was variation in the impact of such feedback based upon both the grade and specialty interest of doctors who participated. However, we have been unable to identify any studies which examine the effect of participating in colleague and patient feedback on the practice of anaesthetists. Other issues include the lack of evidence about whether allowing the clinician to choose their own appraisers makes any difference to the outcome and the difficulties related to the timing of administration of patient questionnaires for anaesthetists.

Therefore, while we have provided guidance for anaesthetists on how to meet this requirement of the revalidation process, we are also committed to further research and developing solutions to some of the problems aforementioned. This might include evaluating whether engaging with these processes leads to performance improvement in anaesthetists, and considering the development and validation of patient feedback questionnaires specific to our specialty. The Health Services Research Centre will be asked to consider undertaking this work and we would welcome information from clinicians and trusts about their approaches to any of the challenges associated with obtaining patient feedback. The College’s guidance on colleague and patient feedback can be accessed at www.rcoa.ac.uk/revalidation and queries can be sent to revalidation@rcoa.ac.uk.

References
This edition of the HSRC update will focus upon the use of quality measures in anaesthesia. These measures will become increasingly familiar to all of us with the development of clinical registries in anaesthetic practice driven, in part, by a requirement to produce outcome data as part of the GMC revalidation process.

This article outlines the background to the quality agenda, and highlights the role of the HSRC in developing this agenda within anaesthesia. Amongst the primary aims of the HSRC is the development of the quality measures that are needed to support the ‘3Rs’: Registries, Revalidation and Research. Before embarking upon the development of novel indicators, there is important work to be done in systematically reviewing the research literature, and mapping the current usage (or not) of quality measures within Great Britain.

‘High Quality Care for All’
The current quality agenda within the NHS is defined by the final report of the 'NHS Next Stage Review', published in June 2008. Lord Darzi, under-secretary of state for Health in the then Labour government, led the review that produced the report. In it, he defined quality in terms of safety, effectiveness and experience. The importance of patient reported outcome measures (PROMs) alongside medically described effectiveness outcomes, (for instance mortality and morbidity) was emphasised. Crucially, these proposals had teeth. Quality performance data would be published, whilst quality improvement would be rewarded through the Commissioning for Quality and Innovation (CQUIN) and Clinical Excellence Award schemes. It was a central mantra of ‘High Quality Care for All’ that change would be ‘locally led, patient centered and clinically driven’. The professions were placed firmly in the driving seat.

Transparency in outcomes
More recently, the current coalition government produced the ‘Transparency in Outcomes’ consultation paper to accompany the 2010 white paper on the NHS. This document outlined proposals for an NHS outcomes framework, and sought feedback on the underpinning principles and structure of this framework, as well as the selection of outcome indicators. The importance of distinguishing between structure, process and outcome was emphasised. Along with other professional organisations, the RCoA responded to this consultation. The professional standards department, with input from the HSRC and others, suggested candidate indicators. However, the paucity of quality indicators in anaesthesia, and the lack of clear consensus on how we should best describe quality in our practice, were very clear.

Where are we now?
Several years into the delivery of the Darzi quality agenda, anaesthesia lags behind other specialties in the systematic measurement of quality. The HSRC is attempting to redress this deficit through several initiatives, including:

➤ Partnership with the Emergency Laparotomy and Hip Fracture Perioperative Networks to work towards a more integrated and systematic approach to data collection.

➤ Completion of two important systematic reviews on risk and outcome measures in major general surgery, led by Dr Ramani Moonesinghe, and funded by the Frances and Augustus Newman Foundation.

➤ A survey that will be sent to all anaesthetic departments in Great Britain during the autumn, asking the profession about which outcomes are measured locally, and which clinical registries are being contributed to.

➤ The formation of a joint HSRC/RCoA working group on quality measurement in anaesthesia, the first scoping meeting having been held at the College in July.

Please engage with these initiatives and support your networks and registries. We welcome approaches (both formal and informal) from anyone interested in being involved in this process, either as a member of the joint working group, or as an investigator in the studies that will be required to develop new measures.
News from the FPM

Professor D J Rowbotham
Dean

It was a great pleasure to meet many of our trainees at their annual meeting, chaired by Neeraj Saxena (Faculty Board trainee representative), and held as part of the British Pain Society (BPS) Annual Scientific Meeting in Edinburgh. Clearly, we have a cohort of enthusiastic and committed young doctors undertaking training in advanced pain medicine, and this bodes well for the future of our specialty. Most of the discussion was extremely positive but, where concerns were expressed, we promised to look into them further through the Faculty Board, Faculty advisors in pain medicine (FAPM), and local education supervisors. Consistency of training throughout UK centres was a common theme. We have, of course, improved this considerably over recent years, but there is more work to do in this area. Also, the FAPMs held their meeting at the same venue, chaired by John Hughes, who is doing a great job as lead FAPM. Many of you would have attended the excellent BPS meeting, and it was gratifying to see how the BPS has embraced the FPM as an important partner in our joint endeavours.

Many medical specialties looking after patients with complex and long standing problems find it difficult to establish a solid evidence base for some areas of their practice. Pain medicine is one such specialty. Although evidence underpins much of our work, there are clear gaps in some of the more complex areas with which we deal. Studies have been published, but they are often small, poorly controlled, and therefore difficult to interpret. Data from these sources are often dismissed by regulatory and commissioning bodies – the recent debacle surrounding the NICE back pain guidelines is a good example of this.

Designing good studies is not that difficult. Models for complex interventions are well established and can be used for many chronic pain questions. However, delivering these studies in terms of patient numbers and data quality is the real challenge. For example, most of them have to be multi-centre and require intricate follow up. The National Institute for Health Research (NIHR) recognised the importance of reliable completion of clinical trials some time ago, and established specialised and comprehensive research networks that deliver quality research studies, utilising many centres in the UK. Pain is represented in this network, but we do not offer the NIHR and other research funders a ready-made group of centres that can take on pain studies, or deliver them on time and on target. The FPM and its partners, especially the BPS, intend to facilitate such a network.

Our proposal is to establish this network utilising the resources of the National Institute of Academic Anaesthesia’s Health Service Research Centre (NIAA HSRC). The first task will be to identify individuals and groups who want to be part of, and develop, a functional research network that can take on often complex and demanding clinical pain studies that will provide the evidence base that our speciality urgently requires. This forum would also be an obvious source of first-class research proposals and grant applications. The UK Perioperative Clinical Research Forum has been recently established by the NIAA HSRC. We want to follow the same model, and a quick look at the NIAA HSRC website (www.niaa-hsrc.org.uk) will give you some idea of how we see the pain project developing.

Please contact us if you are interested in taking part in this venture or have any thoughts on how we should proceed.

Professor D J Rowbotham
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During the last three months, the Faculty has undertaken preparatory work to implement the new ICM training programme, and has worked with the Intensive Care Society and critical care networks to develop an integrated plan for managing patients with acute respiratory failure, as part of commissioning for ECMO. Applications for foundation fellowship continue to arrive undiminished at a rate of around 125 per month; there are now more than 800 foundation fellows, and the application process for trainee membership has now opened.

We have now trained 685 specialists in ICM, and we are producing around 120 to 150 specialists each year, using 226 ICM specialist training posts. Around 150 consultant posts with ICM duties are advertised each year. The consultant workforce survey shows that the majority of trusts plan to expand intensive care facilities. Given the desirable trend towards a consultant-delivered service, which also delivers continuity of care and provides a reasonable balance between work, professional development and family life, we anticipate a considerable increase in demand for ICM specialists over the coming years. Our trainee surveys show that ICM is regarded as a popular potential choice of career by foundation and core trainees, with 90% expressing a preference for dual certification, rather than single-CCT primary speciality ICM. However, a survey of ICM trainees in London reported that around 50% would have preferred a single CCT programme, had it been available to them.

The FICM’s immediate priority is to launch the new ICM training programme successfully. On 15 July we met with the General Medical Council, the Department of Health and the Conference of Post Graduate Deans, to agree the mechanisms and timelines. We have agreed that the new programme (single-CCT and dual-CCT) will start on 1 August 2012. We have also proposed that recruitment to the (‘old’) joint-CCT programme should continue until 31 July 2013, to avoid disenfranchising trainees already in non-ICM specialist training programmes who wish to access ICM training. The GMC will respond to this proposal shortly. We also have broad acceptance that the number of ICM training posts must be doubled within the next year, in order to maintain the current rate of production of specialists. The anticipated increase in demand described above will require many more specialists within the next five to ten years. We believe that the initial increase can be achieved through conversion of non-training posts (trust doctor and fellow posts), and transfer of surplus posts from other specialities to ICM. Regional advisors and training programme directors will need to open discussions now with deaneries and trusts, to see what can be achieved locally. They will also need formally to designate core training posts in anaesthesia, medicine and ACCS, as suitable for ICM training, so that the GMC can accept as ‘transferrable’ the competencies obtained in these posts when trainees enter ICM training at ST3.

One of our other main tasks has been to develop standards for an integrated clinical network for managing patients with acute respiratory failure, as part of commissioning ECMO services. At the request of the specialist commissioners, the Faculty brought together a group to develop a mechanism for integrating up to ten ECMO centres with all ICUs. We have proposed three levels of service. Level 1 will be the majority of ICUs, in which there is continuity of consultant intensivist care, and where lung protective ventilation can be assured with 90% reliability. Level 2 are regional respiratory centres which, in addition to Level 1 standards, can also provide more complex modalities of ventilatory support, longer-term weaning, and have active research and training programmes. Level 3 are the ECMO centres, which would also have cardiothoracic expertise available. There might be several level 2 centres within a region, but only one ECMO centre. ECMO retrieval could be shared across ECMO centres. The critical care networks have shown enthusiasm for adopting these standards under their current structures. Applications for designation as an ECMO centre will be evaluated by interview on 30 and 31 July 2011.
A somewhat reflective title, I suppose, but coming at the tail end of ten years of being one of the first two elected SAS Council members, I think I have earned that right.

When Chris Rowlands and I were elected to Council, we were at somewhat of a disadvantage. Neither of us had any prior knowledge of how any of the medical Royal colleges functioned, let alone our own! We had not been ‘through the mill’, so to speak, of being College officers, for example College tutors, regional advisors, or working on the various committees that make up the life-blood of a college. So, a learning curve that resembled the launch trajectory of the space shuttle was required!

We had a great deal of help from the various consultant Council members who had, in the preceding year, set up the Non-Consultant Career Grade Committee, now entitled the Career Grade Committee. Good teachers point one in the right direction, and then allow one to decide the best approach, giving measured support without crowding or influencing decisions. To that end, I would like to think that, in John Curran and Peter Simpson, we had two of the best. They also had the foresight and wisdom to fill the committee with various co-opted members who already had plenty of political experience in order to temper our enthusiasm and fill the empty cupboards with knowledge that we lacked.

The best part of coming second to Chris Rowlands in the election, was being able to watch and learn from him during the two years that he was a member of Council. For that, I am incredibly grateful, because it gave me the chance to find out where I belonged in the logistics of the Royal College of Anaesthetists. Roger Laishley replaced Chris after two years, and he has more than filled the hole left, ably keeping me out of trouble and giving me a different perspective on the issues that we have faced over the last few years. As to what we have managed to achieve since being elected, I will have to leave that to you ‘out there’ to decide. There are many things about which we do not talk or publicise, perhaps to our detriment. However, the goal has always been to support the grade and to ensure that it has a future in the NHS, whatever shape or form that takes. This is a big unknown for now, given the issues that currently face the government and the rest of us, and making predictions is not, I would venture, productive in the slightest.

I will step down next year and, later this year, the College will be asking for nominations to stand for election, perhaps even before this article is published. I would urge any of you who are interested to stand; we cannot afford to have the seat empty. More importantly, Roger will step down soon also, and it is vital that his successor has the guidance from an ‘old hand’.

I hope that I will be leaving a committee that is stronger and more vibrant than when I started, full of ideas and convictions to carry on where I have to leave off; confident and able to argue points coherently and eloquently, and to be heard by all who should be listening.

Above all, thank you all for giving me the chance of representing you for both my terms of office on Council.

Dr A B H Lim
Chairman
Preoperative assessment for day and short stay surgery

Good preoperative assessment is essential for the delivery of safe, high quality, efficient day surgery. In order to optimise the organisation of a preoperative assessment service, an understanding of the objectives of the service is necessary. Preoperative assessment is a two way process, the hospital gaining information to facilitate the treatment of the patient, and the patient gaining information to understand their relationship to the surgical process, thereby enabling them to make fully informed decisions about their treatment.

Dr M E Stocker
Consultant Anaesthetist, South Devon Healthcare NHS Foundation Trust, Torquay

Dr J E Montgomery
Consultant Anaesthetist, South Devon Healthcare NHS Foundation Trust, Torquay

Organisation of preoperative assessment services

There are many models for the provision of preoperative assessment, but the key components are as follows:

➤ It must be performed early enough in the patient pathway to ensure all necessary investigations and optimisation can be performed.
➤ It should be performed in a location that is convenient for the patient, and enables effective communication of information between the preoperative assessment clinic and the day surgery unit. It must be performed by staff who are trained in medical evaluation for surgery and who are equipped to prepare the patient for their day surgery pathway.

Timing

With ever decreasing periods of time between ‘decision to treat’ and surgery, it is increasingly important to ensure that any preoperative assessment takes place as early as possible. The ideal arrangement comprises the preoperative assessment team running a ‘one-stop’ clinic, enabling patients to attend immediately after their surgical outpatient appointment. However, there are advantages and disadvantages of this model, listed in Table 1.

The key to providing a service that can respond to peaks and troughs of demand requires an understanding of that demand, and the capacity of the service throughout the day, and on different days of the week. With careful planning, it is possible to predict which slots should be available for one-stop patients, and which can be reserved for scheduled appointments.

Table 1

<table>
<thead>
<tr>
<th>Advantages</th>
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<tbody>
<tr>
<td>➤ Eliminates the need for a further hospital appointment for the patient</td>
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<tr>
<td>➤ Ensures the maximum time is available for preoperative investigation or optimisation</td>
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<tr>
<td>➤ Provides a pool of patients who have completed the preoperative assessment process, facilitating rescheduling of patients should a late cancellation arise</td>
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<tr>
<td>➤ Generally popular with patients</td>
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<table>
<thead>
<tr>
<th>Disadvantages</th>
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<tr>
<td>➤ Planning resources (staff/facilities) to deal with unpredictable demand from outpatient clinics</td>
</tr>
<tr>
<td>➤ Providing a service for patients who attend a peripheral site for their outpatient appointment</td>
</tr>
<tr>
<td>➤ Responding to the needs of patients who are unable to stay for a one-stop clinic</td>
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Location

Some units have explored the possibility of telephone or internet based preoperative assessment, but many find that the most efficient and effective service remains a nurse led face to face clinic. Although primary care has a valuable role to play in preoperative optimisation of chronic health conditions such as anaemia and hypertension, most centres find that formal preoperative assessment is more usefully performed within the secondary care setting. Many day surgery units perform their own preoperative assessments and there is some benefit to the patients in visiting the unit where their surgery is to take place, and meeting staff who will be caring for them.
With the introduction of some urgent surgery to the day surgery setting (such as evacuation of products of conception, incision of abscesses and some trauma), telephone preoperative assessment may be necessary in some circumstances.

**Staffing**

Nurse run preoperative assessment clinics, supported by consultant anaesthetists, are the most common successful model in UK practice. There are strong arguments to support the arrangement whereby nurses performing preoperative assessment for day surgery patients are also part of the day surgery ward team, thereby ensuring that they are able to prepare the patient fully for their day surgery episode. There are many aspects of the preoperative assessment process which can be performed by appropriately trained healthcare assistants (for instance, blood pressure recording, venepuncture, ECG recordings, MRSA swabbing), and this releases the registered nurses to perform the medical evaluation and patient preparation. Careful process mapping enables the development of a streamlined service which is appropriately resourced with the correct staffing skill mix. It is important that there is adequate support for the service by anaesthetists with an interest in day surgery. Their role is to review the medical notes of any patients about whom the nurses have concerns, and lead the scheduling of complex patients to optimise their opportunities for successful day surgery. They should also work with the senior nursing staff to develop protocols for the preoperative assessment unit.

**Preoperative assessment has a major role in ensuring that all patients deemed appropriate for day surgery are treated as such.**

**Essential components of preoperative assessment**

**Patient preparation**

For a successful day surgery process with a low unplanned rate of admission to hospital, together with high satisfaction rates, the patient needs to be prepared fully for the day surgery episode, and helped to understand their role and responsibility within in this. For example, following a general anaesthetic, the patient needs to know that they must be escorted home and will need a carer with them overnight. The patient needs verbal and written information about preparations they need to make prior to coming in for surgery, such as what to bring into hospital and when they should stop eating and drinking. In addition to understanding the day surgery process, the patient’s need to understand the nature of the surgical procedure and what to expect during the recovery period. This not only allows them to make informed decisions about their treatment, but also makes them aware of what is normal during the recovery process and, most importantly, when they should call for help if their condition is not as expected. Some of this information may have already been given to the patient during their outpatient assessment prior to listing for surgery, but it may need reinforcing, or the patient may have further questions that necessitate a further appointment with the surgical team. Again, written information regarding the proposed surgery is essential, together with the benefits and risks, because patients are given large quantities of information in a short length of time, and may not be able to recall all of it without reference to an aide mémoire. With the rapid development of enhanced recovery pathways, the essential role of good patient preparation for short stay, and even major surgery, is recognised increasingly. Patients need to be engaged actively in their pre- and post-surgical pathway for optimal outcomes to be achieved.

**Medical evaluation**

All patients presenting for a procedure under general anaesthetic, and some for local anaesthetic procedures, will require medical evaluation prior to admission for their surgery to ensure safe care. Often, this evaluation is conducted as a face to face interview by nursing staff. The purpose of this is to ensure that pre-existing medical conditions are recognised and managed optimally prior to surgery. Staff carrying out the medical evaluation require access to expert advice from experienced consultant anaesthetists to support their decision making, and will also need to work to appropriate protocols. Information gained during this evaluation will aid the planning of the whole list, with rapid patient turn over on the day of surgery, and smooth running of the theatre. Examples include specialist equipment such as hoists, considering the particular needs of individual patients, such as those with diabetes who should be first on the list, or MRSA infection requiring a side room postoperatively and scheduling last on the list. The value of performing preoperative investigations in accordance with NICE guidance for day surgery patients is being reviewed currently. Recent work has shown no difference in outcome in day surgery patients even when all preoperative investigations were omitted.
**Optimisation for surgery**

Following preoperative assessment and with the results of any investigations that were deemed necessary at that time, it may become apparent that a pre-existing medical condition has not been managed optimally. Systems need to be in place to allow time for improvement prior to admission for elective surgery. For these systems to work effectively, there needs to be as long a time period as possible between the preoperative assessment appointment and the proposed date for surgery. The referral to treatment in 18 week pathway (RTT18) makes this more difficult to manage and, indeed, it may be that some of the optimisation required, for example, control of blood pressure and anaemia, should be achieved in primary care prior to surgery, the patient being referred back to their GP. MRSA infection elicited during preoperative screening may also delay treatment whilst a decolonisation regimen is commenced prior to admission.

**Patient selection**

Preoperative assessment has a major role in ensuring that all patients deemed appropriate for day surgery are treated as such. Factors that determine whether a procedure can be performed as a day case for a particular patient will be discussed in a separate section.

**Measuring the success of your service**

The quality of a preoperative assessment service can be evaluated by monitoring rates of both patient cancellations on the day of surgery, and patients who fail to attend for their surgical appointment. Quality is also reflected by patient satisfaction; both with the preoperative assessment process and with their surgical episode overall. Cancellations on the day of surgery and failures to attend will be minimised if preoperative assessment is successful, and patient satisfaction will be optimised by allowing them to understand their role in the process of admission and treatment on the day of surgery, leading to a reduction of anxiety for themselves and their carers.

**References**


**Further reading**


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**AsWeWere**

Anthony White, the senior Surgeon at the Westminster Hospital, was, as I have stated elsewhere, one of the ablest, but certainly the laziest, surgeon of his day. He was a man of consummate ability, and of large resources in difficult or dangerous cases. But his besetting sin was idleness, and this he carried to an extent that seems almost incredible. I believe that he was never known to keep an appointment in his life. Not only was it nothing to him to be an hour or a couple of hours behind time, but he has actually been known to forget the day and go the next; and on one occasion it is positively stated that he was a full week in arrears, having mistaken his appointment by seven days.

It may readily be supposed that White never had a large practice, though he might undoubtedly have been fully occupied had he been a man of business. But to go with him round the wards of the Westminster Hospital, when he did go round, was really a treat. He spoke little, but it was always to the purpose, and what he said stamped him as a man of high philosophical, yet practical, views of Surgery.

White was about the middle height, stout, firmly and rather clumsily built. He was subject to gout, and usually walked slowly and with difficulty. He had a large head, a high and capacious forehead, and an eye of surpassing intelligence. His mouth was large and masculine but his chin wanted that full development that indicates firmness and resolution. He spoke slowly and deliberately. He dressed in black, somewhat slovenly, but always clean.

**Reference**


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As the old saw has it, out of the combinations of cleverness, keenness, stupidity, and idleness, White must have been among the least dangerous of surgeons.

**David Zuck**  
**History of Anaesthesia Society**
Selection criteria for day surgery

In the past, day surgery was a highly selective form of care intended for patients undergoing relatively minor procedures and with few, if any, co-morbidities. The selection criteria in place traditionally were therefore quite strict, in order to exclude those patients who were more likely to experience postoperative complications. However, these early selection criteria, which included rigid limits on age, BMI and ASA grade, proved to be useless at predicting postoperative problems and the need for hospital inpatient admission, or readmission.¹ Instead, they predicted only the occurrence of complications in the immediate perioperative period; problems which could be dealt with on the day, and in a way that did not affect subsequent management and which, once resolved, were still entirely compatible with a safe and uneventful recovery at home.

With increasing experience, it was found that exceeding the predefined limits of the day was still associated with favourable outcomes, such that even selection criteria based on revised cut-off limits² became outdated almost as soon as they were published. There has also been an increasing realisation that rapid recovery and early mobilisation convey positive advantages, including reduced respiratory compromise and venous thromboembolic disease in the obese,³ and reduced postoperative cognitive dysfunction in the elderly.⁴ Consequently, modern day surgery selection criteria include very few absolute limits or rigid criteria.⁵

Current selection criteria
Day surgery selection criteria can still be subdivided according to social, surgical, and medical factors. However, the current philosophy is to reduce reliance placed upon arbitrary limits, and to ensure that the patient is managed optimally and remains relatively stable. In determining suitability for day surgery, there are two important questions to ask:

➤ Is there any benefit to this patient of being in hospital overnight postoperatively?
➤ Is there anything that needs to be done to enable this patient to be a day case?

Social criteria
The most important social criterion for day surgery is the availability of a suitable carer. Current guidance states: 'Following most procedures under general anaesthesia, a responsible adult should escort the patient home and provide support for the first 24 hours.'⁵ The purpose of the carer is to assist the patient with activities which might prove impossible, difficult or painful, and to seek help in the rare event of an emergency. With adequate planning, many patients who normally live alone can make arrangements with a suitable friend, neighbour or relative to act as a short-term carer. However, in the case of a patient who has made a full recovery after a very brief procedure which is not associated with much postoperative pain or the need for sedative analgesia, it is unlikely that the absence of such a carer would significantly reduce the quality or safety of care.

The patient’s home circumstances need to be appropriate for postoperative care. With the exception of some orthopaedic procedures, usually this will be the case if the patient was managing satisfactorily before surgery. A telephone must be available to seek help in an emergency, and a mobile device is quite acceptable. Consideration should be given to the length of the journey home, but there is no evidence to support specific limits. Longer journeys may be more uncomfortable, but should not be prohibited if this is acceptable to the patient. Easy access to emergency care is important, but this need not be necessarily at the hospital undertaking the original surgery. It is worth considering that travelling distances of several hundred miles after day surgery is not uncommon in parts of Europe and North America.

Recent evidence suggests that residual effects of anaesthesia do not impair driving skills by the following day,⁶ but surgical wounds, postoperative pain and the sedative effects of

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Analgesic medications may contradict driving for a week or more after certain procedures.

**Surgical criteria**

Many more procedures have become possible on a day case basis due to the reduction in perioperative physiological trauma associated with minimally invasive surgery. Shoulder repairs, laparoscopic cholecystectomy, simple mastectomy and partial thyroidectomy are commonly performed as day cases by some UK hospitals, whilst laparoscopic adrenalectomy,7–8 pyeloplasty,9 adrenalectomy10 and even awake craniotomy11 have all been performed as day surgery in specialist centres.

With modern anaesthetic techniques, the duration of surgery is a relatively unimportant criterion for day surgery. The main limiting factor relates to whether postoperative pain can be adequately managed with typical day surgery analgesic regimens. There should also be a low requirement for predicted specialist postoperative care, and a low likelihood of a postoperative complication occurring for the first time within four to 24 hours after surgery. In practice, most surgical complications become obvious soon after surgery, and are therefore detected before discharge, or else do not become manifest for several days, by which time the patient would be at home anyway.

Predicting the likelihood of early postoperative complications is often difficult and, in practice, many patients recover far better than expected. It is therefore preferable to manage the majority of patients on a day surgery pathway by default. In this way, they receive consistent care and are prepared for an early discharge. However, if recovery should prove to be delayed or problematic, it is still possible to arrange overnight admission.

A wide range of procedures which are suitable for day surgery can be found in the Procedure Directory from the British Association of Day Surgery,13 although even this list is not exhaustive.

**Medical criteria**

The majority of patients with stable medical conditions such as diabetes, epilepsy, asthma or COPD, receive no additional benefit from an overnight stay in hospital. Indeed, this usually results in the control of the chronic condition being removed from the patient, often with deleterious effect. In contrast, day surgery mandates less of a change in routine, which is usually beneficial in maintaining stability of control.

As with surgical selection criteria, consideration should be given to the likely timing of possible perioperative complications. For example, obesity is associated with difficulty in intravenous cannulation, airway management, surgical access and manual handling. Nevertheless, all of these issues are present however the patient is managed after surgery. Airway and respiratory problems may also complicate recovery, but these are unlikely to persist for more than a few hours after surgery, and are even less likely to present for the first time after an uneventful initial recovery. Obesity should not therefore be seen as a contraindication to day surgery, as even morbidly obese patients can be safely managed through this pathway.13 It is important, however, that these cases are managed by skilled and experienced staff and with appropriate resources, to cope with the difficulties which are likely in the immediate perioperative period.

**Chronic medications**

In most cases, chronic medications should be continued throughout the perioperative period; this includes most antihypertensive medications, where the advantage of simplified instructions may outweigh the small benefit from withholding selected agents.14 Diabetic therapies should be omitted while fasting. The management of anticoagulants and anti-platelet drugs needs to be considered on an individual patient basis, balancing the risks of perioperative bleeding against the hazards of suspending therapy. Advice about medications should be given at preoperative assessment.

**References**

The day surgery patient pathway

The pathway for all surgical patients starts with a consultation with their GP about a problem amenable to a surgical option, and ends, hopefully, with their return to normal health. Although for a day surgery patient the period spent in hospital having surgery will be just one day, all other elements of the pathway will be essentially the same as for any other surgical patient. This article outlines the key stages of the day surgery pathway, its delivery and audit to ensure that the patient receives high quality care.

The primary care consultation

Could it be day surgery?
When patients initially present to their GP with a surgical problem, there is an opportunity for patients to consider the possibility of surgery as a day case. At this stage, surgery will not be a definite option but, if the suggestion is made that day surgery may be offered, patients can start thinking about how they might make the necessary arrangements both on the day, and during recovery at home afterwards. GPs need to be able to access information about the range of day surgery procedures offered by the referral hospital, and any specific criteria required.

Fit to refer?
This initial consultation also provides an opportunity to assess basic fitness for a surgical procedure. This assessment should include a check of BP, BMI, smoking status, and the stability of any chronic diseases such as diabetes, asthma or ischaemic heart disease. If problems are identified at this stage, appropriate management should be instigated, so that patients who are offered surgery are as fit as they can be for the time at which their procedure is planned. In particular, for patients who smoke, referral to smoking cessation services at this early stage will prevent delays, and reduce complications perioperatively. Even if patients are not offered surgery, these basic checks will be of benefit to the patient’s long-term health.

Surgical outpatient appointment

Default to day case booking
When patients attend for consultation with a surgeon, there is a further opportunity to consider the option of day case management. To ensure that all potential day cases are booked as such, it can be helpful to default to day case all procedures with high day case numbers as listed in British Association of Day Surgery (BADS) Directory of Procedures. For many elective cases, a date for surgery can be offered immediately, and this enables the rest of the patient’s pathway to be planned with this date in mind. It also ensures that patients are given a choice, and reduces the chances of their subsequent cancellation.

Intended management as a day case

At this stage, the intended management must be correctly recorded as ‘day case’, to ensure both that patients get appropriate information, and that the hospital performing the procedure is credited and paid for managing the day case. To be counted as a day case, the following criteria apply:

1. The intended management must be recorded as day surgery prior to admission.
2. The patient must be discharged on the same calendar date as the operation.

Whilst this may seem bureaucratic, in practice, it ensures that the patient and those responsible for planning the pathway are aware of the intended management, and can offer the best quality service. If patients expect to spend a night in hospital but are then discharged on the same day, they may not have suitable arrangements in place for their transport or care at home afterwards. They may also feel that they should have stayed in hospital but were only discharged due to a ‘bed crisis’ and, if their recovery is subsequently problematical, they may well feel they have not had the best care.
Informed consent
The surgical outpatient appointment provides an opportunity to start the consent process. The proposed operation will usually be discussed at this point and, where patients are provided with written information, they can take this away to discuss with family and friends so that they are likely to decide against surgery on the day.

Preoperative assessment
The preoperative assessment appointment provides an ideal opportunity for exchange of information between the patient and the team planning their care. Assessment of a patient’s health may lead to investigations and, in some cases, further measures to ensure that their status is as good as possible prior to surgery. An assessment of social circumstances ensures that appropriate arrangements are made prior to admission, including transport and care at home after surgery.

In a small number of patients, management as a day case may not be advisable, either due to lack of social support at home, or because of significant co-morbidity that requires support or observation in hospital after surgery. However, inpatient admission should not be seen as an alternative to optimising a patient’s condition prior to surgery. Where a patient is not fit for an elective procedure as a day case, it is highly likely that the outcome will also be compromised as an inpatient. In contrast, an anaesthetic review, even necessitating a delay until optimised, may enable the patient to be managed as a day case with a better outcome.

Preoperative assessment is discussed in greater detail in a separate section.

The goal of a successful day surgery is the discharge of a comfortable patient who will recover uneventfully in their own home on the day of their surgery.

Admission for surgery
There are several possible arrangements for patients having day surgery that depend upon available facilities, surgeons, operating schedules, and the fitness of the patient.

Different facilities
Some units may be physically isolated from a hospital providing comprehensive services, and may provide either day case treatment only, or sometimes 23-hour stay care. The staff should be experienced in offering care that is focused solely on management as a day or 23-hour stay, so quality and efficiency can be maintained to a very high standard. However, any geographical isolation may mean that additional help cannot be summoned rapidly if a problem occurs, and this factor should be considered when more ambitious procedures are undertaken, or patients with significant co-morbidities are managed.

Integrated day surgery units comprise a dedicated unit with its own operating theatres, self-contained within a larger hospital. These units offer similar efficiency to isolated units, but with a greater provision of back-up facilities. Adequate capacity is often a problem as day surgery expands.

As the proportion of day cases continues to increase, day surgery mixed with inpatient surgery will probably become more common. Operating lists are often planned with a mix of long and short cases to ensure time is used effectively, and short cases are often suitable for day case management. Many surgeons do not have enough in the way of day case procedures to fill a list on a regular basis.

However, it is more difficult to provide good quality care for day cases when they are managed through inpatient facilities, because it is inevitable that both nursing and medical care focuses on the more complex cases. Therefore, day surgery patients are best managed in dedicated ward areas, and preferably scheduled towards the beginning of operating lists to prevent cancellation due to inadequate time for recovery.

Postoperative care
The goal of a successful day surgery is the discharge of a comfortable patient who will recover uneventfully in their own home on the day of their surgery. The management of the patient throughout the pathway, from the time of GP referral, will determine how likely this is to be achieved. Prior preparation, both physical and mental, contributes significantly to the chance of success, as does the attitude of the staff caring for the patient. Patients in specialist day surgery facilities benefit from the expertise and focus of staff compared with patients managed on inpatient wards, who have a higher chance of an unplanned overnight admission.

Analgesia
Good pain relief is crucial when providing a high quality of care, and may be managed most effectively with a pain management protocol. Patients must be comfortable, but also able to mobilise, eat and void within hours of their surgery. Discussion about pain management should start during the preoperative assessment to ensure patients have realistic expectations, and understand how they will manage their pain at home after discharge. Patients must be discharged with appropriate analgesia for the likely severity of pain, and be given clear
Day case rates as a percentage of total surgery provide an indicator of success at every stage from booking and planning, to perioperative care and discharge. If measured rates are not as high as suggested in the BADS Directory of Procedures, each stage of the pathway should be examined to identify where and why problems are occurring.

Rates of ‘cancellation on the day’ may indicate a problem with the protocol for preoperative assessment although, in some cases, new problems develop that could not have been foreseen.

Operations that are deemed unnecessary by the surgeon on the day, point towards a problem of decision making during the surgical outpatient clinic. On the other hand, if the patient subsequently decides that they no longer want the operation, there may have been a problem in the process of communicating details of the proposed surgery to the patient.

High rates of patient non-attendance (DNA) indicate problems with selecting and communicating dates to patients. Planning dates for surgery with patients at an early stage should reduce risk of clashes with holidays for both patients and potential carers.

Monitoring of these parameters on a regular basis is necessary to ensure that patients are receiving high quality care in the most appropriate environment. As greater experience is gained and new technology becomes available, more and more patients should be able to benefit from receiving care as day cases.

References
3 Recovery for day surgery units. BADS, London 2007 (www.bads.co.uk).

Discharge
Nurse led discharge should be routine for day surgery patients. Criteria for discharge should be clearly communicated, and include generic criteria for all general anaesthetic cases, together with some specific criteria that apply to certain procedures or types of anaesthesia.

Specific skills and equipment such as a handheld ultrasound for bladder scanning can be helpful to ensure that patients at risk of voiding difficulties are identified and managed appropriately before discharge.

Recovery at home
Return to normal health is the goal of the pathway for a day surgery patient. Patients should be given any information necessary to help them manage their own recovery at home. This should include realistic expectations for return to normal activity, management of common complications, and contact numbers for further advice during or out of normal opening hours. Follow up by telephone the day after discharge is a useful opportunity for staff to monitor the patient’s recovery, and for patients to discuss any problems.

Measuring success
A day case pathway involves complex interactions between medical, nursing and administrative staff in both primary and secondary care, and patients and their carers. It is neither surprising that there are many opportunities for success or failure to varying degrees, nor that there are many ways that the success of the day case pathway can be measured.
Benchmarking day surgery performance

Advances in anaesthetic and surgical techniques over the last decade have prompted a re-evaluation of recommendations for safe and effective practice for patients undergoing operative procedures on a day care basis. Exemplar day surgery units in the United Kingdom embracing such developments have been able to show what is feasible with a timely model of care, in the troubled times of our health economy.

The ongoing radical transformation of healthcare provision in England has placed emphasis upon delivery of improved efficiency and value for money which, for day surgery, goes hand in hand with the prime clinical driver of better patient care. This is an ethos that the British Association of Day Surgery (BADS) continues to support, by emphasising the potential enhancement of quality components and outcomes possible with similar transformation of the patient pathway for elective surgery, and from which such economies should follow naturally. So, how do we accommodate and adapt to such remits?

There is a benefit from the involvement of clinicians, who are given the time required to develop enhanced day surgery care. Some of the recommendations from the Healthcare Commission review of day surgery in 2005 stated that ‘trusts should ensure that there are clear responsibilities for consultant supervision of day surgery units’, and that they should ‘work closely with clinicians within individual specialties to investigate reasons why greater proportions of elective surgery are not done as day cases’.1 A consultant anaesthetist with management experience is ideally suited to such a leadership role, and job plans must reflect this responsibility.2–3 However, the inheritance of this role demands not only an awareness of the surgical procedures that are now feasible for day surgery care, but also an insight into the options that are currently available for individual hospitals to audit their in-house performance.

21st century day surgery care: what is feasible?

Historically, the Audit Commission ‘basket of 25’ was used as a template for benchmarking day case operations and, until recently, such data have been collected and disseminated nationally. However, the ‘basket’ has a number of serious limitations:

➤ it includes only 25 procedures, giving the impression that others are unimportant
➤ it includes procedures such as hysteroscopy, and carpal tunnel decompression, which are increasingly being managed in outpatient environments under local anaesthesia
➤ it does not indicate what proportion of each procedure should ideally be performed on a day case basis, implying that all procedures are similarly easy (or difficult) to manage as such.

In addition, with the advent of more minimally invasive surgical intervention, procedures such as laparoscopic nephrectomy, adrenalectomy, thyroidectomy and parathyroidectomy have been proven to be feasible as day surgery procedures in some cases, whilst many more can be managed safely and effectively on a one day stay basis. Over the last five years, BADS has been advocating that this template should be regarded as redundant, because it reflects 20th century practice rather than indicating what might be more appropriate for the second decade of the 21st century.

In 2006, BADS developed and published a Directory of Procedures,4 that is now in its third edition, and provides a more contemporary template encompassing guidelines for the length of stay deemed feasible for over 180 day and short stay procedures. Within the context of the recommendations is recognition that some procedures may require longer postoperative recovery or observation times, thereby mandating a morning operating session, together with a potential need for specialised...
There is a benefit from the involvement of clinicians, who are given the time required to develop enhanced day surgery care.

Royal colleges, specialist associations, trusts and individual clinicians, using a variety of sources. One of the more influential review sources has originated from the Association’s production of the concomitant ‘digital’ Procedure Directory.

The ‘Digital’ Directory: BEAT
Three years ago, BADS developed an additional adjunct to the procedure directory in the form of a suite of Microsoft Excel® programmes called the BADS Efficiency Assessment Tool (BEAT). This software enables individual hospitals to enter their own length of stay data and evaluate the use of overnight beds in comparison with directory recommendations. BEAT also provides an intuitive efficiency score that is provided at individual procedure, specialty and organisational levels, a score of 100 indicating achievement of the aspirational benchmarks, and higher or lower scores commensurate with a percentage of either overachievement or ‘some way to go’. Figure 2 shows an example screenshot of the spreadsheet for breast surgery from one organisation, with the calculation of bed utilisation based upon the data entry, together with the derived efficiency score. The programme produces similar data for all surgical procedures in the directory, with a summary of both specialty and

The BADS Procedure Directory
The Procedure Directory is divided into sections evaluating surgery in nine surgical specialties. For each of these, Hospital Episode Statistics (HES) data were used to identify the highest volume procedures worthy of inclusion, as well as adding more surgically challenging, yet lower volume operations where it was known that some organisations had successfully translocated care to a shorter stay pathway. Specific OPCS inclusion and exclusion codes are provided to ensure accurate and consistent reporting of the defined procedures, whilst recommendations for length of stay are divided into those for true day surgery (admission, treatment and discharge on the same calendar day), 23 hour stay (effectively one night stay), and less than 72 hours, equating to a two night stay. An additional stimulus for providers was the identification of some procedures where operative care could be managed in a suitably clean environment outside the standard operating theatre. Clinical leaders within the field of day surgery provided the initial insight into the feasibility of the proposed benchmarks that were published after further review by BADS Council members. Figure 1 shows an example page from the current directory, with advocated lengths of stay for breast surgery. Since the first edition, there has been evidence-based enhancement and amelioration of some of the recommendations, with input from equipment and training to achieve the suggested benchmarks. So, whilst it might be perceived that the recommendations are potentially utopian, the Association remains convinced that these are achievable targets for the next five years, albeit with a need for lead clinicians to evaluate and redefine care pathways in their hospitals that embrace a more ‘joined up’ view than previously. It is no coincidence that the originating ethos of the Enhanced Recovery Programme has its ancestral roots embedded in optimised day surgery pathways, as was cited in one of the original papers by Wilmore and Kehlet in 2001, where the authors stated, ‘Use of these methods in day surgical units will be extended to more complex surgical procedures, thus decreasing length of time in hospital.’
organisation bed use (Figure 3). Users of BEAT have the opportunity to submit their anonymised data back to BADS, providing the benefit of peer cross comparison, as well as providing a ‘snap shot’ view of progress towards the benchmarks advocated in the Procedure Directory. ‘Flagship’ day surgery units in England currently are attaining overall efficiency scores of between 80 and 90 for bed utilisation, with the operations reviewed.

**Adoption of the Procedure Directory benchmarks**

The publication of the first edition of the Directory in 2006 was a defining landmark in the history of BADS, given a recognition that the association had both insight and expertise with the provision of advice regarding best practice for one day care, that could similarly be applicable to the short stay environment encompassing one or two night stays. In the intervening five years, components of the Directory, either in part or in entirety, have been adopted by the Audit Commission (as a more relevant benchmarking replacement for their original ‘basket of 25’ procedures), NHS Scotland, the Welsh Audit Office, the NHS Institute for Innovation and Improvement (via the ‘better care’ indices), the Department of Health Payment by Results Team (with development of best practice tariffs for selected day surgery procedures) and commercial benchmarking companies such as ‘CHKS’.

There is continued evidence of a wide variation in rates of day surgery in the UK, for which there appears to be little explanation beyond perhaps local intransigence, a lack of recognition of what might be feasible, or a sense of inability on the part of clinical leads to influence entrenched pathways. The dissemination of the Procedure Directory and BEAT seems to have acted as a stimulus for a number of national organisations and local providers to take advantage of the opportunities afforded by advances in perioperative anaesthetic and surgical management. There is also evidence that commissioning organisations are starting to use such comparative information and benchmarks to the benefit of a cost constrained service, with the more important end result of the improvement in patient care that optimisation of day surgery pathways can bring.

**References**

Spinal anaesthesia for day surgery

Spinal anaesthesia is still reserved largely for inpatient surgery in the UK, perhaps because of concerns about delayed recovery and postoperative urinary retention. However, suitably modified spinal techniques can extend access to day surgery for patients who might otherwise be excluded, by offering a suitable alternative to general anaesthesia.

This article addresses the benefits, practicalities and challenges of using modified spinal anaesthesia in an ambulatory setting.

Advantages of spinal anaesthesia for day surgery patients

The advantages of neuraxial block for selected patients undergoing more major surgery are well known. For day surgery patients, spinal anaesthesia also provides excellent early postoperative analgesia, reducing the requirement for opioids and their associated unwanted side effects, and promoting rapid recovery and discharge. Patient groups who may gain particular benefit from the availability of spinal anaesthesia in day surgery include the elderly, the obese, and those with diabetes.

General anaesthesia is associated with a number of problems in the aged, who often have co-existing disease, exhibit diminished functional status and physiological reserve, and may demonstrate age-related pharmacodynamic and pharmacokinetic changes.\(^1\) Spinal anaesthesia mitigates some of these problems and has been associated with reduced postoperative morbidity and mortality.\(^2\)

Obesity, whilst not a contraindication to day surgery, is associated with a number of co-morbidities which may increase risks when associated with general anaesthesia. These include obstructive sleep apnoea (OSA), gastrooesophageal reflux disease (GORD) and Type 2 diabetes. Patients with OSA who are managed under spinal anaesthesia without sedation may be suitable for day surgery. Using spinal anaesthesia for those with GORD avoids risks associated with airway instrumentation, whilst for patients with diabetes, reduced postoperative starvation time enables most to be managed without intravenous insulin, and a return more rapidly to their normal diet and diabetes medication.

Given the choice, some patients would prefer to avoid general anaesthesia, whilst others are keen to observe and understand their operation. Specific written patient information about spinal anaesthesia is available from the Royal College of Anaesthetists.\(^3\) This provides details of benefits and risks (for example, post-dural puncture headache) and is equally suitable for day surgery patients.

Modifying spinal anaesthesia for day surgery

The aim of any modification is to produce effective, short acting spinal anaesthesia with minimal postoperative complications. The term ‘selective spinal anaesthesia’ (SSA) has been used to describe the practice of employing minimal doses of intrathecal agents, so that only the nerve roots supplying a specific area, and only the modalities that require to be anaesthetised, are affected. SSA can be achieved by using a reduced dose of local anaesthetic together with an adjuvant, and by adopting a variety of manoeuvres to control the spread of the block.

Important considerations when evaluating the literature on day case spinal anaesthesia include the contents of the intrathecal solution, injection technique, patient positioning and outcome measures. The latter may include failure rate, time to independent ambulation, incidence of urinary retention, and unplanned inpatient admission.

Currently in the UK, preparations with licensed indications for intrathecal use are:

- hyperbaric bupivacaine, 0.5%
- ‘plain’ bupivacaine, 0.25% and 0.5%
➤ levobupivacaine, 0.25% and 0.5%
➤ hyperbaric prilocaine 2%.

The last has become available only recently, so experience is limited, but intrathecal prilocaine appears to be shorter acting than bupivacaine. Lidocaine has fallen out of favour because of its association with transient neurologic syndrome (TNS), which comprises post-anaesthetic buttock and leg pain of variable intensity, occurring with dose-dependent frequency.

Determinants of the extent and duration of spinal blockade

The baricity of the injectate combined with patient positioning can be used to restrict the spread of the block. ‘Plain’ bupivacaine is slightly hypobaric with respect to cerebrospinal fluid at 37°C, whereas ‘heavy’ bupivacaine remains hyperbaric with respect to cerebrospinal fluid even with the addition of small doses of fentanyl. The dose of local anaesthetic is the main determinant of block duration, although there is wide inter-patient variability.

Where the intention is to produce a restricted block (saddle or unilateral), a slow injection has been used to restrict the spread of local anaesthetic. Pencil-point spinal needles are preferred because of their established association with a lower incidence of post-dural puncture headache. Directing the orifice in the spinal needle to the operative side may help to enhance the block on that side.

The synergistic effect of adding fentanyl allows the use of doses of bupivacaine that would normally be considered subtherapeutic, reducing block failure rate, and extending the duration of analgesia. The safety and efficacy of intrathecal fentanyl are well established although it is associated with self-limiting pruritus in a high proportion of patients. The ‘off-label’ use of intrathecal fentanyl is widespread.

Assessment of the block for surgery

SSA is often associated with loss of pain sensation in the blocked area whilst other modalities are affected to a variable but lesser degree. Qualitatively, SSA is quite different from conventional spinal anaesthesia and, in consequence, traditional testing methods (application of ice, light touch, motor block, etc) may not be suitable. Subtle, early indications of a working block are a subjective sense of warmth or tingling in the affected area, and a modest fall in diastolic pressure.

Techniques for day surgery procedures using low-dose bupivacaine

Low-dose bupivacaine can be used to produce a qualitatively ‘thin’ block over a large body area or a denser block, restricted to a smaller area. Where surgery is unilateral, deliberate targeting of the block to the operative side is widely recognised as beneficial.

Hyperbaric bupivacaine 2.5–5 mg with fentanyl 10–25 µg injected with the patient in the sitting position, produces a saddle block suitable for haemorrhoidectomy, and vulval, perineal and penile surgery.

Predominantly unilateral lower limb block has been achieved using both ‘plain’ and hyperbaric solutions. Using ‘plain’ bupivacaine, the operative side must be placed uppermost either before, or immediately after, the spinal injection, whereas using hyperbaric solutions requires that the operative side should be dependent. A recent review concluded that hyperbaric bupivacaine 4–5 mg is a suitable dose for knee arthroscopy with unilateral positioning.

A lower torso block suitable for inguinal hernia repair has been achieved using hyperbaric bupivacaine 8 mg, hyperbaric bupivacaine 7.5 mg with fentanyl 25 µg, and ‘plain’ levobupivacaine 5 mg with fentanyl 25 µg. Depending upon other patient factors, postoperative urinary retention may be a significant risk, and hernia repair under local anaesthesia may be a better option.

Intraoperative troubleshooting

Inadequate block

No spinal technique is infallible, but success is more certain when attention is paid to detail as outlined above, and meticulous care is taken to avoid loss of injectate (for example, between the syringe and spinal needle).

Options for augmenting unsatisfactory spinal anaesthesia include repeating the spinal injection, adding a local anaesthetic block, local anaesthetic infiltration by the anaesthetist or surgeon, or the use of intravenous opioids – fentanyl and alfentanil are suitable. Patients who complain of pain or discomfort during surgery should be promptly offered reassurance and supplementary analgesia. On occasion, resort to general anaesthesia may be necessary.

Hypotension

In contrast with conventional spinal anaesthesia, SSA is rarely associated with significant hypotension because the sympathetic block is less profound. Overdistension of the bladder during the period of detrusor paralysis can,
however, predispose to retention of urine, and sympathomimetic drugs (rather than excessive intravenous fluids) should be used as first-line management of hypotension.

**Pruritus**

Intrathecal fentanyl commonly causes pruritus, which is both self-limiting and generally well tolerated. Reassurance is usually all that is required. The role of intravenous ondansetron in attenuating symptoms is unclear at the time of writing.

**Recovery and discharge**

In comparison with uneventful general anaesthesia, patients mobilise more slowly. However, optimising the dose of local anaesthetic together with judicious planning of the operating list will minimise delays in discharge. After spinal anaesthesia using low-dose bupivacaine, return to independent, non-assisted ambulation also requires adequate proprioception. This typically follows approximately one hour after return of full motor power.15

**Urinary retention**

Low-dose spinal anaesthesia is rarely associated with urinary retention in patients who are otherwise at low risk for this complication. In consequence, voiding, which has traditionally been a prerequisite for discharge, is no longer considered necessary for low-risk patients. Ultrasound scanning of postoperative bladder volume facilitates management in high-risk patients. Local guidelines should be developed in collaboration with urologists for postoperative bladder management.

**Post-dural puncture headache (PDPH)**

The frequency of PDPH requiring epidural blood patch in ambulatory populations following puncture with small (24–27 G) pencil-point needles has been estimated at 0.5–1%.16–17 Specific patient information should include details of how to access help in the event of headache developing after discharge. Any patient with a significant headache after dural puncture should be assessed by an anaesthetist, and managed in the conventional way.

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Enhanced recovery after surgery

Day surgery should be the default choice for all surgery, but when inpatient treatment is unavoidable, patients should be given care of equally high quality. Enhanced recovery pathways are designed to offer the inpatient equivalent high quality care.

Enhanced recovery pathways for surgery, alternatively known as ‘fast-track’, ‘accelerated’ or ‘rapid recovery’, were first described by Wilmore and Kehlet over a decade ago.1 Their work demonstrated that, by combining various techniques in the perioperative care of patients undergoing elective operations, the stress response to surgery and consequent organ dysfunction was reduced, and that this greatly shortened the time required for full recovery. The methods used included comprehensive preoperative preparation, epidural or regional anaesthesia, minimally invasive surgical techniques, optimal fluid management and pain control, and aggressive postoperative rehabilitation, including early enteral (oral) nutrition and ambulation. It was recognised that the underlying principles had already been adopted in day surgery, and extension of the same principles for more major surgery brought equal success. Although first described in patients undergoing colorectal surgery, the approach was soon adopted with benefit in other specialties, including orthopaedic surgery.2

Evolution of the enhanced recovery programme in the UK

Whilst the concept has been used extensively in Denmark, uptake of this multimodal approach has generally been slow in the UK, despite the excellent outcomes where it has been adopted, including a dramatically reduced period of hospitalisation after major colorectal surgery. More recently, a few individual surgeons have recognised the need for improvement, and have adopted the approach with considerable success.3 The Improving Surgical Outcomes Group (ISOG), an independent medical group comprising surgeons, anaesthetists, critical care consultants and others involved in perioperative management and care, had also recognised the need for major improvements and, in June 2005, the group produced a report entitled ‘Modernising Care for Patients Undergoing Major Surgery’ which was presented to the House of Commons Select Committee in 2006.4

The Department of Health responded to the approaches made by clinicians asking for help to spread enhanced recovery practice, and the clinically led Enhanced Recovery Partnership Programme (2009–2011) was designed to help clinical teams to implement, and managers to understand, the benefits for both patients and the health system. The programme sought the expertise of clinical teams already implementing the pathways both in the UK and abroad and, as a result, produced a guide which provides a starting point to support implementation of enhanced recovery.5 Professor Sir Mike Richards, National Clinical Director for Cancer, and Chair of the Enhanced Recovery Partnership Programme Steering Group, wrote in his introduction to the guide that:

‘[the enhanced recovery pathway] improves quality of care by helping patients to get better sooner after major surgery. Secondly, it reduces length of stay with obvious benefits to the NHS. The Enhanced Recovery Programme is therefore fully aligned with Lord Darzi’s High Quality Care for All, with quality as the organising principle for the NHS. It also amply fulfils the quality and productivity criteria of the Quality and Productivity Challenge (QIPP).’5

Expertise to date has centred largely around colorectal, musculoskeletal and, more recently, gynaecology and urology as specialties, but it is anticipated that the general principles of the enhanced recovery pathway can be transferred to any patient, in any specialty.
Anaesthetists, critical care and pain specialists have a pivotal role to play at every stage of the pathway ...

The pathway

Just like day surgery, the enhanced recovery pathway starts in primary care with the GP referral to the specialist, and continues through to follow up of the patient at home after discharge from hospital; this, therefore, requires a local health community approach. The patient becomes a partner in their own care, and should share in decision making at every stage, starting with the decision to opt for surgery or other treatments.

The patient should:

▸ be in the best possible physiological condition for surgery
▸ have the best possible management before, during and after surgery
▸ experience the best possible rehabilitation.

Necessary elements identified by expert groups are shown in Figure 1, although not all elements apply to all types of surgery.

For enhanced recovery strategies to be effective, the multidisciplinary team needs to work in a coherent way to deliver both the clinical and the organisational elements of the pathway. Building this multidisciplinary team at local level to agree the basic principles, improve efficiency surrounding the pathway, increase awareness of patients about the process, and facilitate early discharge planning using agreed criteria, are all part of the different approach.

As for day surgery, preoperative preparation is absolutely key to delivering good outcomes, and needs exemplary organisation and attention to detail. There should be a clear system for ensuring that patients follow the appropriate pathway of care, either day surgery or inpatient/ enhanced recovery, and that those patients who require admission are assessed for individual risk, and are admitted to the appropriate facility for their needs. Some organisations implementing enhanced recovery pathways have used additional support strategies, such as 'joint schools' for major joint surgery, to increase the understanding of patients and their carers about what will happen to them and, therefore, their ability to participate actively in their own recovery.

Local 'fitness for referral' agreements with general practitioners can prove to be particularly helpful, but require close co-ordination between preoperative assessment clinic leads and primary care.

Detailed description of all elements of the pathway is outwith the scope of this article but they are covered in the guide, and elsewhere. Goal directed fluid therapy and pain management are further areas where anaesthetists can contribute particularly.

Discharge should be planned from the outset, with clear expectations understood by all. Assessment of likely needs after discharge, and the involvement of social services, can prevent delayed discharge of a patient who is clinically fit to return to the environment from which they were admitted.

Informed decision making and consent

Enhanced recovery pathway design helps clinical teams to improve the informed decision-making process. Informed decision making can be defined as "everything that takes place before a patient finally agrees or consents to a treatment, procedure
or investigation’. It also focuses on the way that patients make decisions, and how we can best help them to assess the risks and benefits of treatment options in a shared decision-making process.

There are a growing number of decision-making aids designed to help patients understand their choices and possible alternatives to surgery. Some of these can be found on the NHS Direct website.¹ In combination with individualised risk assessment, these tools are enhancing the ability of patients to access meaningful information on which to base their decisions.

**Critical success factors and barriers**

A number of factors play a key role in the success of enhanced recovery, and several barriers must be surmounted to ensure its implementation.²

Enhanced recovery will fail without teamwork, so executive and clinical champions or leaders are essential. Surgeons, anaesthetists, nurses, executive management, commissioners and primary care must work together towards implementation; there must be consensus-building during the introduction phase, and there must be collaboration with social services, ambulance services and primary care to ensure effective transfers of care.

Involvement of all stakeholders and continuous feedback to them and the clinical team delivering the care should not be underestimated. Strategies to help with implementation include:

- using small scale tests of change
- rolling education of ward staff, junior doctors and other members of the multidisciplinary team, to ensure that everyone knows what is required of them
- including patients as partners in their care by ensuring that they know what will happen to them, have a planned discharge date, and follow up after discharge.

Barriers which will hinder effective implementation include:

- inadequate communication and/or consensus building
- reluctance of clinicians to change practice
- failure of managers to see the benefits both to patients and to the organisation.

**Data collection and outcome measures**

Routine data collection is a prerequisite for the assessment of the quality and effectiveness of elective care pathways. Reliable and valid measures of risk and outcome are essential,³ and include:

- morbidity and mortality
- readmission rate
- length of hospital stay
- patient reported outcome measures (PROMs).

In order to inform improvement, it is also essential to capture patient experience both at an individual patient level, and at a service level.

**Summary**

Elective care can now be considered to follow either day case or enhanced recovery pathways, and these should become the accepted standard of care, and part of a continuum, with day surgery being the ultimate in enhanced recovery.⁴ Careful design, evaluation and a system for continuous improvement will lead to both high quality care for the patient and efficiency for the organisation. There is no reason why these principles cannot be adopted in emergency and medical settings, right across the spectrum of inpatient care.

Anaesthetists, critical care and pain specialists have a pivotal role to play at every stage of the pathway and enhanced recovery pathways take full advantage of our extensive perioperative skills. These need to be complemented with well developed managerial and leadership skills, and a commitment and enthusiasm to fundamentally contribute to improving surgical outcomes.

**References**

Recruitment 2012 – steps in the right direction

As the National Recruitment Process becomes established, changes to the arrangements are planned for 2012. Some of these involve refining detail. Other changes are significant, and will affect dramatically the way that recruitment into specialty training takes place.

Twice-yearly recruitment – back to the future?
The Department of Health (DH) has agreed to allow two rounds of recruitment to all grades of training, with the second round taking place in the autumn, for posts starting in February. The ramifications are immense, both for our specialty and for the underlying pattern of core training.

The biggest unknown factor is the potential source of the applicants for the February posts. Where will they come from? Will they be doctors who have done six months in medicine or surgery before seeing the light and switching to anaesthetics, or will they be anaesthetists in training who decide to move to another part of the country? It seems likely that switching to twice-yearly recruitment will make it much easier for trainees to change specialties, or to take a more ‘roll your own’ attitude to career planning. It is also certain that it will create several new headaches for programme directors.

How will the annual review of competency progression (ARCP) be organised for trainees who are six months out of synchronisation with the mainstream? Will the ARCP process become a bi-annual requirement? My own feeling is that the ‘mega’ ARCPs that occupy large chunks of the summer will end up being divided, and programme directors can look forward to arranging additional ARCPs in the Christmas holiday period as well.

Another unsolved headache for programme directors in all specialties, is the problem generated by doctors in core training programmes who leave at the end of January in order to enter alternative training programmes. Who will replace them for the second half of their original programme?

The switch to twice-yearly recruitment could lead to a situation similar to that before 2007, when doctors were able to sample different specialties before settling on a final career. How this will pan out in practice, and whether our own specialty will benefit or lose out, remain to be seen.

ACCS anaesthesia versus the anaesthesia training programme

Applications for anaesthesia and ACCS are to become unified: a single application form, a single recruitment process, and a combined ‘offers process’. Applicants will be able to express preference for either the direct route or the three-year ACCS route.

Recruitment into emergency medicine and acute medicine ACCS will be conducted separately. Applicants will be able to apply for each of these if they wish, as well as to other specialties at the same time. Some applicants will not be eligible for ACCS, because they will have spent time already in the complementary specialties, and these more senior applicants will be expected to apply for anaesthesia alone.

Candidates need to be made aware that there is no automatic right of transfer from one ACCS stream to another and that, if appointed into an emergency medicine exit ACCS programme, they cannot transfer to an anaesthetic programme without going through a competitive recruitment process.

The ACCS route is a longer one than the direct anaesthetic route, but doctors who have taken this course will get a broader training, and the experiences they gain will be useful later in their careers. There are many who feel that all trainees in anaesthetics should do ACCS training, particularly in view of the entry requirements into intensive care.
medicine. The additional experience should be a feather in their caps for the future, and we should encourage applicants to look closely at the benefits of the three-year programme.

From a recruitment perspective then, anaesthesia and the complementary ACCS specialties will continue to work together, and interview panels will be encouraged to have a cross-specialty composition.

Some programme directors will consider whether the number of ACCS programmes can be increased, and local changes will underpin this. It seems likely that programmes offering more ACCS places will be more popular amongst candidates.

**ST3 candidates without the full Primary**

The College is keen to end the so called ‘Category 2’ scheme for those applying for ST3 posts who have not passed the Primary FRCA (or equivalent). Prior to 2010, trainees who had not passed the examination were not eligible to apply for ST3 posts. With the introduction of annual national recruitment, this regulation was changed, and applicants who were in the middle of the Primary FRCA examination in May each year were permitted to apply, and were offered a post provisionally, contingent upon them passing the examination before taking up the post.

This change caused chaos, and programme directors up and down the country were seen ‘tearing out their hair’ when dealing with the consequences. The implications are that, just two months before the start date, it has been necessary to rescind an unpredictable number of offers. This has repercussions for the number of CT2 posts and automatic post extensions, and has led to last minute interviews during the summer holidays that have not been straightforward to manage.

The College and DH have agreed that Category 2 should be abolished, but that this change should be delayed until 2013...

One of the chief reasons for introducing Category 2 was the yearly recruitment process. With the change to twice-yearly recruitment, there is no longer a valid rationale.

The absurdity in all this has been that core trainees who fail the Primary FRCA examination at the end of two years may be offered an automatic extension of their training programme, whilst, in contrast, those who pass the examination may find themselves without an extension, and also without a job. So, paradoxically, there is a significant disincentive for trainees to pass the examination.

The College and DH have agreed that Category 2 should be abolished, but that this change should be delayed until 2013, so as not to disadvantage the present cohort of trainees. It is planned that the full Primary FRCA or equivalent will be required in order to apply for ST3 after this date. However, the College is looking carefully at the ramifications and inconsistencies, and the situation may still need to be reviewed.

**Workshops, surveys and briefings**

In the spring the RCoA Recruitment Committee organised surveys of the applicants, interviewers and deanery staff who were involved in recruitment. The views expressed have been considered carefully, and many of the current plans for 2012 and beyond are based upon this feedback.

In the autumn, we will be arranging a series of briefings for deanery and other staff, at which we will present the details of our proposals for the coming year, and will run through the precise timing and organisation.

**UKOFFS – did they really call it that?**

‘UKOFFS’ is the new National UK Offers Process, which had originally been planned for 2011, but is now scheduled to start in 2012. This process should bring major improvements for applicants, and will allow them much more control over the offers process and preferencing, within programmes and specialties.

The DH is committed to making this process work, and many hours have been spent poring over minute details. At the time of writing, the algorithms have been agreed, and the programmers and testers have got the rest of the summer to complete the implementation. One important feature is ‘upgrading’ – the process of moving applicants into their preferred programmes if vacancies become available. UKOFFS is a DH initiative, and is being managed by NES in Scotland. The RCoA and the West Midlands Deanery are hoping to be involved in the formal testing process.

**CT1 and the ‘almost-guaranteed interview’**

The intention this year is that all applicants to CT1 should be offered an interview in their first-ranked unit of application (UoA). However, there is some hesitation before making a firm promise, in case one single deanery becomes deluged with applicants, and cannot cope with the numbers of interviews that would be required.

Instead, the proposal is that all CT1 applicants will be offered an interview in their first-ranked UoA but, if the numbers concerned make this
impractical, the weaker candidates will be offered an interview in their second choice UoA. How this will work in practice will depend upon applicant behaviour and the numbers of available posts. Based on this year’s process, the College is hopeful that this proposal will work well, and will result in a much fairer system.

**ST3 – up to two interviews**

This year, the College intends to continue with the present system of allowing ST3 applicants to apply to two UoAs and, possibly, to secure two interviews. There is some pressure, mostly financial, to move to a single application, and some other specialties have adopted this approach. We have resisted this, particularly because the interview scoring needs to be refined if it is to become more consistent. The financial pressures are not likely to go away, and there may be a need to revisit this in future years.

**Changes to the interviews and shortlisting**

This year the application form and the portfolio station will converge. The application form will become the basis of the portfolio station.

Where numbers are tight in oversubscribed parts of the country, self-scoring of application forms may be used in part. In this model, the candidate awards themselves points for previous predetermined criteria, for example, possession of a BSc, and the total is presented on the application form. However, self-scoring is not without problems, for example in assessing doctors who have had unusual career paths, and probity is a key consideration.

The interviewers will review the self-scored part of the application form, and the intention is that the portfolio station should become ‘shortlisting with questioning.’ Candidates will be asked to justify, explain, and expand upon their application form. In many ways the portfolio station will resemble a traditional-style interview where candidates are asked to present their past career progression and their career intentions, as well as being assessed on organisation, commitment to programme, and commitment to career.

The Recruitment Committee is also looking carefully at stations concerned with the structured interview and presentation. The scorings and guidance to interviewers need to be revised. One of the clear lessons from this year was that some questions worked much better than others, and a bank of questions will be developed that can be shared.

Quality assurance of the interviews is also on the agenda, including the development of a calibration interview at the start of the day, which will allow interviewers to ‘dry run’ their questions, and iron out any ambiguities and problems. The use of visiting consultants from other parts of the country is also being considered, and funding has been secured to provide training for interviewers with the introduction of an online assessor training package for 2012.

**Website and information to applicants**

As part of the redesign of the RCoA website, we are hoping to have a unified recruitment page, bringing together information from the College and the West Midlands Deanery into a single site. The information to applicants is all being carefully scrutinised.

UoAs will be required to return data to the West Midlands Deanery in a standard format and using standard templates, so lessening the risk of confusion and misunderstandings.
Since its inception, SALG has flourished and continues to develop in order to meet the needs of the speciality. Its membership has expanded over the last three years, to include representatives from medical and nursing professions, administrative risk management and human factors experts, in addition to many specialist professional societies. The Group now has nurtured a 650 strong network of safety enthusiasts, and a forum of administrative risk managers – nearing 200 contacts. Subsidiary to the core and co-opted members, a Data Analysis Group (DAG) is now being convened, to provide in-depth analysis on the reported events. This new group will analyse both individual reports with the most serious outcomes, and aggregated data which highlights hazards thematically.

Successes for SALG – notices, alerts, meetings and networks
True to its purpose, SALG has used critical incident reports to produce summaries of data, as well as some in-depth analyses of potential hazards in anaesthetic practice. The anaesthetic eForm project was the driver behind the original formation of SALG. It had become apparent that there was disengagement of anaesthetists, traditionally a specialty with an enhanced reputation for reporting and learning, because they felt that ‘nothing was being done’. Part of this problem related to the generic nature of the available reporting tools. The eForm offered an anaesthesia specific dataset, so that anaesthetists could record the factors that they felt had caused an unexpected outcome. In turn, weekly review of the deaths and severe incidents and quarterly summaries of all reported data began to reinstate the impetus to report incidents in the first place.

In October 2009, the SALG safety notification ‘Guaranteeing Drug Delivery in Total Intravenous Anaesthesia’ was published, followed by the first summary of incidents, which was met with enthusiasm. Since then, each publication has been met with a more vocal response. The ‘Stop Before You Block’ campaign, which is now available for national implementation by visiting www.rcoa.ac.uk/ is a piece of shared learning stimulated by an individual doctor on the safety network. After identifying with the SALG safety notification ‘Preventing Wrong Site Blocks During Surgery’, the doctor, from Nottingham University Hospitals, made contact with SALG to share the locally agreed solution. This has now been endorsed, and we wait with interest to see if its implementation brings about a significant decrease in this recognised problem. Nottingham was not the only Trust to respond, and a collection of articles and studies from around the country can be found at the same URL.

The use of the e-Form
The anaesthetic eForm is an enhanced tool that records more specific data. This leads to higher quality analysis and more relevant feedback. We anticipate that the dedicated DAG will also improve turnaround and depth of feedback. The launch of the anaesthetic eForm has raised the profile of reporting in anaesthesia, and opened a dialogue about the role of reporting in the safety culture. The anaesthetic eForm workshops, at which the tool was launched, highlighted the importance of the relationship between members of the clinical and administrative teams, in order for a successful safety culture. The reporting process must fulfil the needs of
The area of human factors can be a daunting one, but is something that SALG will be looking at more closely in the coming months.

Our liaisons with national and international organisations
SALG has actively supported implementation of the WHO checklist as a stakeholder in the Patient Safety First campaign, whose reputation, nationally and internationally, continues to strengthen. The anaesthetic eForm is one among other anaesthesia specific national reporting systems for serious untoward incidents (SUIs). The German system, (DGAI), the Swiss system (CIRS) and the New Zealand system (ANZCA) are the other three established systems, whilst Spain is setting up its own system currently. Anaesthetists in the USA are also developing an anaesthesia specific system for SUIs as a subsidiary to their clinical audit programme (NACOR), and have been in contact with SALG to discuss how the reporting drives learning. Colleagues in Italy and Sweden have also enquired with a view to setting up their own systems. SALG will strengthen its liaisons with all these international developments in order to further enhance cross-learning at all levels.

SALG after the NPSA ceases to function
The face of safety in the UK is changing. The abolition of the NPSA may have sent a mixed message about its future value to the NHS as well as its credibility with the Department of Health. However, SALG has been re-assured that safety remains amongst the top priorities of the Department of Health, and that the National Reporting and Learning System (NRLS) will continue under the functions of new NHS Commissioning Board. The Presidents of both the College and the AAGBI are already in communication with the Board to ensure that the interests of SALG are recognised. Formal and informal correspondence to that effect will continue, until the position of safety on the new NHS agenda is confirmed and the flow of anaesthetic data to the SALG DAG is guaranteed.

Safety Conference, 3 October 2011
Human factors – areas of interest after the safety conference
Following the success of the Safety Conference in 2010, the 2011 conference (which will take place on Monday, 3 October) promises to be a day of great educational value. Concentrating on team-working and human factors, delegates will be asked to consider skills which are too often taken for granted. Aspects of a safe operating theatre, for example communication, delegation and situational awareness, are often over looked. The conference hopes to engender a debate about the ways in which these skills can be analysed, measured and manipulated.

The area of human factors can be a daunting one, but is something that SALG will be looking at more closely in the coming months. There may be times when experience does not enhance consultants’ performance but, instead, hinders it. The ability to question one’s own practice, to re-address the behaviours that have become habit, and to accept that they may have been practising unsafely, is a skill which can, and should, be learned. SALG accepts that human factors training or learning will not be the same for doctors at all levels, and will make every effort to supply safety information pitched at a level which resonates with clinicians at all stages of their career.
How to get involved
The number of clinicians engaged in the culture of safer practice will be a mark of the success of SALG. The safety network is the quickest and easiest way to get involved, and anyone can join. Simply email the SALG administrator at SALG@rcoa.ac.uk to sign up. Within your Trust, your relationship with your administrative risk manager and with the other professionals in the theatre team will be the key to your overall success. Talk to them about safer practice, ask your risk team to join the SALG risk management forum, and agree upon a mutually beneficial route for implementing change.

SALG also urges you to keep reporting incidents. Whether via the anaesthetic eForm, or LRMS, sharing experiences is one the most valuable contributions that the anaesthetic team can make to safer practice throughout the specialty.
College Census report

At the beginning of this article, it is worth noting that it is becoming increasingly difficult to obtain workforce information from the NHS for any of the four UK home countries. For this reason, we are especially grateful to representatives who submitted information to us from anaesthetic departments, and also for the efforts of College Tutors in particular, who were involved directly in generating census returns. We appreciate that this work was not easy.

This census centred originally upon a snapshot date in late 2010. However, several hospitals were unable to provide data by the specified date and, therefore, returns were accepted until early 2011, thus facilitating a remarkable 100% return rate. It is acknowledged that this 2010–2011 census does not, as a result, provide data for a single targeted snap-shot day, neither were we privileged to receive completed returns answering every one of the questions on the census return form. However, and very significantly, we did receive key data from every anaesthetic department in the UK, and each response was verified locally. In addition, we received responses about the eight principal areas which contribute the most to the workforce analysis. The information supplied by the significant majority of contributors to the remaining questions, provided a valuable resource and will be used as indicative data for consideration in other workforce and service projects in the very near future.

The analysis below concentrates on the key data returned, and we believe that this is the most current and accurate UK-wide anaesthetic workforce analysis available. We have been made aware of other national and regional studies within the UK, and their respective authors have generously agreed to share this data with us so that we may continue to refine our information; this will be reflected in subsequent Bulletin and RCoA website articles.

Finally, the Faculty of Intensive Care Medicine (FICM) is, at time of writing, undertaking an ICM specific workforce study. This will offer specialty data and a further level of workforce intelligence to contribute to the ongoing, all-encompassing, anaesthetic workforce projects being undertaken by the College, with key partners in all UK departments of health, and their respective workforce organisations, most notably the Centre for Workforce Intelligence (CfWI).

In comparison with 2007 data, there is an increase in consultant numbers working to contracts attracting ten PAs or higher. We
observed a 10.9% overall increase on the 2007 figure of 5,645 for totals across the UK. There is considerable variation for the individual countries with the extremes being a 13% increase in Wales, but only 1.6% in Northern Ireland.

Figure 1 also presents a slight increase in the female proportion for consultant posts; in 2007 this was 28.8% and for this report the figure is 30.3%.

Data in Figure 2 shows, rather remarkably, that the total UK number for consultant anaesthetists working to contracts of less than ten PAs remains constant at 588. However, a notable variance occurs when the figures for Scotland are considered separately. There is an increase of 25% from 40 less than full time consultants in 2007, to 50 now.

In Figure 3 we note the total number of consultant anaesthetists working across the UK against all forms of contract are 9.9% higher than in 2007. However, the proportion of total workforce across the UK has slightly changed in Northern Ireland – down 0.3%, and in Scotland – up 0.5%; no significant changes noted for England and Wales.

The data for Figure 4 represents career grade anaesthetists in positions as staff grade, associate specialist, specialty doctor, trust grades and other similar, non-consultant, positions. The 2007 total for such positions across the UK was 1,879 and for this census 1,843, a reduction of 1.9%. Proportional figures by country remain very similar, with a notable decrease in Northern Ireland from 1.65% of the total UK numbers of SAS/SD grades, down to just 1% now.

A significant area of concern for employers across the NHS has been increasing difficulty in filling vacant anaesthetic posts. Figure 5 shows a total of 525 unfilled positions; 244 at consultant level and 281 for other career grades. For the same question in 2007, there were 421 vacancies. A variety of reasons for this increase were demonstrated in the
This article presents the data from the latest census, enabling comparison with the similar project undertaken in 2007. A fundamental benefit of the presentation is that it looks at the UK as a whole. A breakdown and further analysis of the data above, and the additional return data not presented here, will be fundamental for anaesthesia workforce planning over the next three years.

For information and reference, a copy of the complete census questionnaire, together with a larger version of this report, can be viewed in the professional standards area of the College website at www.rcoa.ac.uk/census.

General comments
One of the areas previously represented in census reports, but missing here, has been that of trainee grades and numbers. It became obvious very quickly in this census cycle, that trusts and boards were struggling to provide this data in an accurate form. The most up to date information on trainees can only be provided by individual training programme directors and deans, and this is not yet available in an integrated form from across the UK. However, the College initiative to produce an e-portfolio for trainees will require every anaesthetic trainee to register and submit information that can then be interrogated centrally, and will provide reports containing general trainee workforce information, personal information that will, of course, remain securely protected at all times. We plan for this information to supplement the census data above, and to be available for analysis early in 2012.

free text areas of the census returns, and included financial uncertainty, reconfiguration of services locally and at trust or board level, and geographical unpopularity. In many areas the gaps are being filled by locum staff. However, there is an indication that, in a significant number of hospitals, existing staff are filling the gaps with extended work patterns, or increased PAs on individual contracts.

Figure 5
Total number of unfilled positions
Targeted training for the Initial Assessment of Competency (IAC)

Very few novice trainees have had previous exposure to anaesthetic training because of the short time spent in anaesthesia during their medical school and foundation years. The demands of the specialty can prove challenging, if not daunting to novice trainees, who cannot work unsupervised until they successfully complete the Initial Assessment of Competency (IAC), usually within three to six months. After receiving feedback from trainees, our hospital has introduced ‘targeted training’ to overcome these challenges. This comprises a ‘route map’ and a handbook, detailing aims, checklists and progress reports for individual trainees, and much greater use of training tailored to individuals. It has resulted in much reduced IAC completion times, within an average of eight weeks, allowing trainees to maximise training opportunities.

Novice trainees in anaesthetics face a big challenge, because they need to acquire new skills and knowledge in a relatively short period of time, and this is a daunting prospect for the majority. During the author’s time as College Tutor (2005–2008), the importance of completing the IAC quickly was recognised, and this prompted the introduction of ‘targeted training’, enabling trainees new to anaesthesia to acquire skills and knowledge within a structured programme, in order to be able to anaesthetise simple cases with distant supervision. Having an interest in reflective practice (at this time I was studying for an MA in clinical education), several informal interviews were conducted with all the trainees to better understand their issues and difficulties when commencing a new specialty.

Trainees highlighted two main issues: the importance of structure in a relatively large curriculum, and duplication of topic teaching. Trainees noted that, given the volume of knowledge and skills required, they were unsure which topics to prioritise and master within the first few weeks. They recognised the importance of taking charge of their own learning, but needed greater direction regarding the structure. It was also evident that there was significant duplication of topic teaching in the theatres by different consultants. Insufficient communication meant that consultants were not always aware of what had already been taught by their colleagues. Correspondingly, it was also noticeable that, by the end of three months, there were several important concepts in anaesthesia that were not always explored by either the trainees or the trainers.

We aimed to target training in the initial months of anaesthetic practice with an aim of standardising and improving the quality of training. This has resulted in the creation of the following route map for trainees and consultants in the department, to maximise training opportunities and allow trainees the chance to direct and take charge of their own learning.

Route map

There is an introductory session with all new starters where the route map is explained and trainees are reminded that they need to take charge of their individual learning aims.

All trainees are given a trainee knowledge and skills handbook which contains:

➤ An essential knowledge checklist, fundamental to the clinical duties when first on-call (Appendix 1).

➤ A practical airway skills log recording, for example, each successful insertion of a laryngeal mask airway (LMA) or endotracheal tube, rapid sequence induction etc.

Trainees use the handbook in three ways: as an aide mémoire, as a way of listing their learning against the checklist, and as a way of informing consultants about what has been achieved and which areas still need to be
All trainees are given a specific date ranging between six and eight weeks by which they should endeavour to achieve the IAC, providing them with a goal to aim for.

After four weeks, trainees spend two or three half days in the recovery room to complete the recovery training module. Although it took a couple of years to get this embedded into the routine, the recovery staff have now developed excellent relations with the trainees.

Experience of emergency work is essential, so trainees shadow the on call team after four weeks, particularly out-of-hours and at weekends, to observe and practice emergency work under supervision.

Since 2009, all the new trainees have attended a weekly ‘novice’ course over four weeks, with an aim of providing a broad understanding of the practical provision of anaesthesia. This course has focused upon delivering the basis of anaesthetic practice, and includes formal lectures, practical workshops for anaesthetic equipment and airway skills, interactive discussions, and screen based and mannequin based critical incident teaching.

If an opportunity arises, the trainee is sent on a transfer of a critically ill patient with a senior colleague.

During the first four weeks, the listed topics are taught individually in theatres, and followed for the next four weeks during which the trainee’s knowledge is assessed to ascertain their readiness for achieving IAC (Figure 1). This is advantageous, because all topics are repeated so that the process contributes to ‘spiral learning’. It is also expected that they will achieve at least 50 LMA insertions and 50 endotracheal tube insertions during this period.

Their handbook is checked every few days to ensure that they are on course, and to get feedback from the trainees about any perceived difficulties. They are encouraged to use e-Learning Anaesthesia (e-LA) as much as possible.

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During the second month, the trainees start to complete their assessments as detailed in the Initial Assessment of Competency section of the RCoA CCT training programme. Finally, feedback from consultants is sought about their readiness for doing on-calls.

All trainees are given a specific date ranging between six and eight weeks by which they should endeavour to achieve the IAC, providing them with a goal to aim for.

During the first four weeks, the listed topics are taught individually in theatres, and followed for the next four weeks during which the trainee’s knowledge is assessed to ascertain their readiness for achieving IAC (Figure 1). This is advantageous, because all topics are repeated so that the process contributes to ‘spiral learning’. It is also expected that they will achieve at least 50 LMA insertions and 50 endotracheal tube insertions during this period.

Their handbook is checked every few days to ensure that they are on course, and to get feedback from the trainees about any perceived difficulties. They are encouraged to use e-Learning Anaesthesia (e-LA) as much as possible.

During the second month, the trainees start to complete their assessments as detailed in the Initial Assessment of Competency section of the RCoA CCT training programme. Finally, feedback from consultants is sought about their readiness for doing on-calls.

All trainees are given a specific date ranging between six and eight weeks by which they should endeavour to achieve the IAC, providing them with a goal to aim for. After this period, competencies are checked and feedback from trainees is sought about their perception of their readiness to start on-call. If they are not ready by the specified date, the competencies achieved are checked, and a new date is agreed for further IAC, and the competencies not achieved are targeted for completion of the revised IAC.

Figure 1
And the outcome?
From August 2007, 15 trainees including eight acute care common stem (ACCS) CT2 trainees with various exit specialties have undertaken targeted training. The average mean time taken to achieve the IAC and to commence on-call commitments was eight weeks (range six to 12 weeks). This has proved to be particularly helpful for ACCS trainees with non-anaesthetic exit specialties, because they generally felt that this programme gave them structure, enabling them to balance their own examination preparation with new anaesthetic learning. Out of eight ACCS trainees, six achieved their IAC within eight weeks (with two achieving it at six weeks).

Feedback
Initial set up required negotiation and the engagement of the consultant staff, recovery staff and trainees. However, once everyone was on board, the trainee feedback was excellent. They felt they had a framework from which to work, and were able to cover all the knowledge and skills required in the initial weeks. The consultants felt that the programme was much improved with targeting training of individual needs, and they are now very supportive of the programme. As a result, training is more consistent and effective, and changes have been incorporated with very helpful suggestions from both the trainees and the consultants.

The reduction in hours worked means that training needs to be focused to maximise the benefits, and achieve the standards required to work without direct supervision. There is an obvious need for keen and dynamic consultants who are enthusiastic about taking on the responsibility of training novice anaesthetists, and such training needs to be tailored towards individual trainees. Trainees have been able to take the IAC competencies well before the expected timeframe, and this allows between two and four weeks of additional training time that is not always required, so that trainees can contribute to the on-call rota earlier than the expected three months.

Acknowledgement
This work would not have been possible without the help and enthusiasm of my colleagues in the anaesthetic department in Medway NHS Foundation Trust.

This work was presented at the Ottawa conference in 2010 as a short communication.

Reference
1. CCT in Anaesthetics, Annex B – Basic level training (www.rcoa.ac.uk/CCT2010).

Appendix 1
The main headings in the essential knowledge/skills base document are:

1. Drugs: indications, contraindications, dosage, side effects
2. Anaesthetic equipments
3. Perioperative pain relief: indication, contraindication, dosage and side effects
4. Preoperative assessment of the patient including interpretation of preoperative investigations
5. Rapid sequence induction: indications and how to do it
6. Anaesthetic machine
7. Critical incidents encountered during and after anaesthetics; aetiology and how to deal with them
8. Recovery topics

College tutors can access the detailed document in the secure area of the College website for College officials under 'School Training Materials – South Coast School'.
The demand for attendance at the National Audit Project 4 (NAP4) launch days has been considerable. Both days in March and July were oversubscribed with a considerable waiting list. Whilst the possibility of a third NAP4 day was considered, use of technology should make this unnecessary. The College has recorded all the lectures from the original launch day at the Royal College of Anaesthetists, and is making them available as video podcasts to download to desktop, laptop or mobile devices.

The recording and editing of the lectures have been organised by Dr Audrey Quinn, and Mr Geoff Cross, using a combination of Macintosh ‘screen capture’ technology and videoing of the lecturer (Figure 1).

Figure 1
ScreenFlow screencasting (Telestream, California)

The software programme captures the contents of a Mac desktop, video camera, microphone and computer’s audio.

These files can then be downloaded onto any desktop, laptop or mobile device as video podcasts via iTunes or QuickTime. Alternatively, the video podcasts are available to download from the NAP section of the College’s website at www.rcoa.ac.uk/nap4.

The podcasts will show the presenters’ slides with an inset video of the lecturer delivering the presentation (Figure 2). The NAP4 lecturers kindly agreed to the recordings and to making edited versions of their short presentations available after the launch.

Figure 2
Screenshots of some of video podcasts

The NAP4 launch day consisted of 20 presentations all of about 10–12 minutes, delivered by the review panel of the NAP4 project. All 20 video podcasts are available via
The College is set to introduce lecture capture software by the end of this year which will allow online access to some key lectures and events, and the ability to view content via mobile devices.

We will also be looking at how to put this technology to best use for established educational programmes, such as using the built-in question and answer facility available to trainers and participants.

We hope the NAP4 podcasts and our future initiatives will be of use to the College membership, many of whom are likely to be already embracing such technology. Please do provide feedback to the authors or editor.

iTunes or QuickTime directly from: www.NAP4.podbean.com (any queries, please email geoffcross@mac.com) or via the College website at www.rcoa.ac.uk/nap4.

After clicking on the link, the screen in Figure 3 should appear. Of note, if accessing the link from work it is likely that some hospitals will block the site (a common problem with many hospitals) and access may need to be arranged with the local IT department or via home computers! The link is also to an encrypted site and you may be asked to 'accept the certificate as valid'. You should do so – there is no risk in doing this.

To download the podcasts click 'subscribe with iTunes'.

The next screen will appear as in Figure 4. Clicking on the podcast starts the download.

Each podcast will take a few minutes to download, depending on the length of the lecture and the speed of the internet connection. The downloaded podcasts can be played immediately, or stored on the computer to play at your convenience on either a desktop or a mobile device.

The 20 podcasts each last approximately 12 minutes and aim to summarise the main points in the NAP4 chapters. They cannot cover the NAP4 project report in full, but do provide an overview. We would recommend reading the original publications in the British Journal of Anaesthesia together with the full report which can be accessed and downloaded at www.rcoa.ac.uk/nap4.

We hope these video podcasts provide an opportunity for individuals to access the launch day lectures if they have not been able to attend. They can also be used within a department as a way of presenting some or all of the topics covered in NAP4.

The release of these video podcasts marks the start of the College’s wider plans to introduce high quality web streaming, as a means of widening access to selected educational meetings and events.

The College is set to introduce lecture capture software by the end of this year which will allow online access to some key lectures and events, and the ability to view content via mobile devices.

We will also be looking at how to put this technology to best use for established educational programmes, such as using the built-in question and answer facility available to trainers and participants.

We hope the NAP4 podcasts and our future initiatives will be of use to the College membership, many of whom are likely to be already embracing such technology. Please do provide feedback to the authors or editor.
What now for NAP?  
The future of the National Audit Projects

This article aims to summarise briefly the recent changes in the organisation of the National Audit Projects (NAPs), and explain the process for selecting the topic for NAP5 and beyond.

The Health Services Research Centre and NAPs

NAPs 1–4 were supported and managed by the Professional Standards Department of the Royal College of Anaesthetists. In 2011, the Health Services Research Centre (HSRC) of the National Institute of Academic Anaesthesia (NIAA) was launched, with the aim of being a hub for world-class anaesthesia research (including perioperative, pain related and sub-specialty research). Now, the responsibility for management of the NAPs has been transferred to the HSRC, with oversight by Council of the College. My future role is one of co-ordinating lead (as opposed to project lead) of the NAPs.

The NAPs now have a national (arguably international) profile, and it is important that the momentum gained by the recent NAP reports is maintained. It is equally important that future NAPs are relevant, well supported, well conducted and deliver a high quality product, addressing a clinically relevant issue.

NAP3 and NAP4

NAP3 and NAP4 examined infrequent events (NAP3 – permanent harm caused by neuraxial anaesthesia, NAP4 – major complications of airway management during anaesthesia, in emergency departments and in intensive care) and attempted to determine the incidence of such events. Both projects, in addition to refining quantitative aspects of these problems, also collected a large number of case histories which were examined in depth to identify qualitative learning from such rare complications. Another achievement common to both projects has been to focus the attention of the profession and other specialties on the problems under examination: in effect to ‘shine a light’ on the problem. Both projects have led to changes in practice and have likely already contributed to improved care in the areas studied.

A model similar to those used for NAP3 and NAP4 appears logical for subsequent NAPs, and is likely to continue the focus on rare complications. For the chosen topic, this involves first determining a denominator, if not already known, and then identifying and reviewing a cohort of index events to determine a numerator. NAP3 reviewed 90 events in one year, and included 30 in (pessimistic) incidence calculations. NAP4 identified 280 events in one year, and included 186 in final analyses. Events that occur either too rarely or too frequently may be difficult to study, and NAP3 and NAP4 perhaps represent useful indicative limits of what is both informative and manageable. Other methodologies might be suitable for NAP5, and will not be excluded from future projects.

Another important aspect of the NAPs relates to the bi-partite partnerships central to their conduct. For NAP3 the College was joined by the National Confidential Acute Pain Critical Incidents Audit of the British Pain Society and, for NAP4, the Difficult Airway Society was the College’s partner. Whilst many other partner organisations contributed significantly to both projects, such partnerships have an important role, with NAP-leads from both organisations working together to steer the project in the right direction.

NAPs ‘out to tender’

In late 2010, a call was made for proposals for NAP5, through advertisements in anaesthetic journals and on the College website. The advertisement emphasised that, as with recent NAPs, the topic recommended would likely meet the following criteria, being:

➤ important to patients
➤ important to anaesthetists
a topic that is currently incompletely studied in incidence or nature.

Those responding to the article were asked to complete a proforma indicating:

➤ a clear definition of the proposed topic with a clearly defined question
➤ a topic of broad interest to anaesthetists (in other words relevant, and able to engage interest)
➤ a topic for which the question to be answered is currently unanswered.

The proposer was also asked to indicate their interest in leading NAP5, or to recommend a potential lead.

**NAP5 proposals**

There were a total of 43 proposals covering 35 separate topics (Table 1), and several were suggested on multiple occasions (Table 2). Some proposals were well worked up with a clear structure, identified individuals capable of delivering the project and included the backing of an appropriate specialty or sub-specialty organisation. Others were considerably less well developed.

The list of topics and submitted full proposals was considered by the HSRC executive and a short-list produced. Reasons for not short-listing topics included:

➤ more suitable for research methodology (for example, a prospective cohort study) rather than registry
➤ suitable for specialist society audit rather than national audit
➤ complications not significant enough to generate national interest and compliance with NAP
➤ impracticality of study of subject
➤ previous study undertaken by other audit programmes (for instance ICNARC, NCEPOD, SHOT).

### Table 1

Topics proposed for NAP5 presented in alphabetical order

<table>
<thead>
<tr>
<th>Topic</th>
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<tbody>
<tr>
<td>Anaphylaxis</td>
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<tr>
<td>Asthma management</td>
</tr>
<tr>
<td>Awareness</td>
</tr>
<tr>
<td>Cardiopulmonary bypass: complications of perfusion</td>
</tr>
<tr>
<td>Cardiothoracic critical care risk assessment</td>
</tr>
<tr>
<td>Central line complications</td>
</tr>
<tr>
<td>CME and CPD: compliance and benefits</td>
</tr>
<tr>
<td>Coronary stents: complications in the perioperative period</td>
</tr>
<tr>
<td>Dental damage</td>
</tr>
<tr>
<td>Elderly: complications of anaesthesia</td>
</tr>
<tr>
<td>Fractured neck of femur: reasons for cancellation</td>
</tr>
<tr>
<td>Hypotension during anaesthesia: use of vasopressors and other agents</td>
</tr>
<tr>
<td>Long-term sequelae of anaesthesia</td>
</tr>
<tr>
<td>Obesity: incidence and complications</td>
</tr>
<tr>
<td>Paediatric delivery and complications during anaesthesia</td>
</tr>
<tr>
<td>Patient information at time of anaesthesia: delivery and quality</td>
</tr>
<tr>
<td>Percutaneous dilatational tracheostomy: early complications</td>
</tr>
<tr>
<td>Perioperative myocardial infarction</td>
</tr>
<tr>
<td>Perioperative patient preparation: fasting, nutrition, pre-medication practices and compliance</td>
</tr>
<tr>
<td>Perioperative relief: practice and quality</td>
</tr>
<tr>
<td>Peripheral nerve block complications</td>
</tr>
<tr>
<td>Peripheral nerve injury from patient positioning during general anaesthesia</td>
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<tr>
<td>Post operative nausea and vomiting</td>
</tr>
<tr>
<td>Pregnancy at the time of surgery: compliance with national guidance</td>
</tr>
<tr>
<td>Recovery room complications</td>
</tr>
<tr>
<td>Recovery room indicators of quality</td>
</tr>
<tr>
<td>Robotic and laparoscopic surgery with prolonged steep head-down positioning: complications</td>
</tr>
<tr>
<td>Sedation: major complications throughout hospital</td>
</tr>
<tr>
<td>Tracheal stenosis and permanent harm following airway instrumentation</td>
</tr>
<tr>
<td>Tracheostomy: complications</td>
</tr>
<tr>
<td>Transfusion complications</td>
</tr>
<tr>
<td>Transfusion requirements and practices during cardiac surgery</td>
</tr>
<tr>
<td>Transport: complications of transport, particularly oxygen failure</td>
</tr>
<tr>
<td>Unplanned ICU admissions from theatre</td>
</tr>
</tbody>
</table>
The shortlisted topics were reviewed in greater depth to assess:

- importance: is the question important to patients and clinicians?
- novelty: is the posed question currently unanswered?
- practicality: would a NAP be able to answer the posed question?
- suitability: would a different methodology be better suited to answering the question?
- difficulty: are there factors making the proposal difficult or impractical?

The favoured topic for NAP5 was selected and a series of planning meetings were devised to refine the topic and question to be answered, and to identify partner groups and potential leads for the project as well as to formally plan the project. At the time of writing, these meetings are still in place and the topic for NAP5 is not completely finalised so, although this article will not announce the topic for NAP5, in fact it is likely that the topic will have been announced before this article is published.

### Table 2

<table>
<thead>
<tr>
<th>Topic</th>
<th>Proposals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness during general anaesthesia</td>
<td>4</td>
</tr>
<tr>
<td>Head-down and laparoscopic surgery complications</td>
<td>2</td>
</tr>
<tr>
<td>Paediatric anaesthesia delivery and complications</td>
<td>2</td>
</tr>
<tr>
<td>Peripheral nerve block complications</td>
<td>4</td>
</tr>
<tr>
<td>Sedation complications</td>
<td>2</td>
</tr>
</tbody>
</table>

### NAP6 and onwards

The future of NAPs is dependent upon the success of NAP5 and subsequent projects. These in turn depend on the enthusiasm and active involvement of individual anaesthetists, local reporters, anaesthetic departments, and the approval of hospital management. These are major challenges that all will need to respond to in order to maintain the success of the NAPs.

The process of tendering for NAP5 has produced a number of high quality proposals which might be suitable for NAP6 and beyond. Formal requests for re-submissions are likely within the next 12 to 18 months to enable adequate forward planning.

### Potential changes to NAPs

Compared with equivalent research projects, NAP3 and NAP4 were delivered on very modest budgets, and can be considered to have been excellent value for money. Whilst most costs were met by the College, significant contributions were made by the main partner organisations, and directly or indirectly by supporting organisations. It is recognised that there was an immense reliance placed on the local reporters in hospitals, often acting within their own professional or personal time.

The College is currently examining how the quality of future projects can be maintained at a time when there is increasing pressure on costs at all levels of the NHS, and when professional leave is an ever dwindling resource. The College is exploring ways of formally supporting the position of national project-lead in a manner similar to other College positions. Ways in which the already considerable administrative support provided by the College (and from other partners) can be developed to reduce administrative tasks for the project-lead may also be examined. It is hoped the position of project-lead will attract high quality applicants for future NAPs.

Finally, it is recognised that the role of the NAP local reporter in hospitals may need to be more formalised. Improved recognition of the post as a suitable use of supporting professional activity (SPA) might be a first step.
Watch out!

A reference for a Certificate of Eligibility for Specialist Registration (CESR) application is different

Dr A E Thornberry, Medical Secretary of the Training Committee, RCoA

In the world of reference writing, a recent trend has included the use of a structured reference tool aligned to both the post applied for, and the domains of the GMC’s Good Medical Practice (GMP). Referees acting for applicants for a CESR are now asked to complete a structured reference aligned to GMP, and the difference between this and previous formats is worth documenting.

The biggest single difference is that one is not writing a reference for a specific post, but writing a reference that supports the applicant’s possession of appropriate training or experience, such that their competencies are equivalent to a holder of the Certificate of Completion of Training (CCT). This enables the applicant to apply for any consultant appointment advertised within the NHS. You are not being asked to comment upon whether they are suitably trained to perform as a consultant within your establishment, nor are you being asked to relate whether they were a good trainee when they were attached to your department.

Agreeing to be a referee for a CESR application should not be taken lightly. The onus is on the referee to review the guidance, and assimilate the knowledge needed to deliver a well constructed reference. It is essential to understanding the general and specialty specific guidance, together with knowledge of all stages of the curriculum.

There is some excellent guidance to help complete the structured reference. The GMC webpage ‘Guidance for Referees’ includes a ‘sample of the standard structured report form’ which goes through each section in detail. Guidance from the College is available for applicants, assessors and educational supervisors. Section 21 refers to the importance of choosing the correct referees, and cites examples of pitfalls to avoid.

GMP section 1a asks whether the referee considers the applicant to possess the breadth of experience and the skills required as specified in the 2010 curriculum. This may be difficult for one referee to assess if they have only worked with the doctor in one hospital. It is clear that skills and competencies not covered within that post should be otherwise defined. A good candidate will have evidence from another referee to demonstrate skills in other areas. Candidates are also able to obtain testimonials from clinicians who are able to comment upon the competencies in the various sub-specialties, as listed in the curriculum.

Evidence that an applicant engages in continuing professional development (CPD), clinical governance and audit, is usually easy to obtain, as is evidence of good communication, teamwork and teaching. More difficult to document are generic skills as listed in domain 4b, where one is asked to confirm that the applicant treats patients and colleagues fairly and without discrimination, for example ‘is honest and objective when appraising colleagues, writes references, gives constructive feedback, raises issues of colleagues’ performance and responds promptly to complaints’. Many applicants who are working in the UK currently are not expected to perform these roles. If you know someone in your department who may be applying to the specialist register in the future, it may be helpful to give them some of this kind of responsibility.

Probably the most important section of the reference asks the referee whether they will lend support to the applicant for approval for specialist registration. One is being asked to confirm that, in one’s personal opinion, the applicant has had equivalent training and experience to UK trainees. The questions to consider include being able to give the candidate 100% support or ‘qualified support’, which acknowledges that there are aspects upon which it is not possible to comment. It may even be that the best support one can give to an applicant is to recommend a different referee. Alternatively, it may not be possible to support an applicant for good reasons, and these should be carefully documented, because such references constitute an equally valuable addition to the process.

References
1  www.gmc-uk.org/SGPC__Guidance_on_completing_a_structured_report_for_a_CESR_or_CEGPR.pdf_31296430.pdf.
2  www.rcoa.ac.uk/docs/Eqc.pdf.
In 1958, the British Oxygen Company (BOC) funded the foundation of a Chair of Anaesthesia. The BOC chair was last held by Professor Leo Strunin at the Royal London Hospital. Inflation, improved salaries, and the requirement by university employers for overhead costs means that, in the 21st century, there is no longer sufficient funding to found and support a new chair of anaesthesia. Instead, the Royal College of Anaesthetists has reinterpreted the resource as the BOC Grant, given as a four-year resource to a promising academic who is close to promotion to professorial status. Four years ago, the BOC Grant was awarded to Dr Tony Absalom from Cambridge, who researched brain imaging and drug disposition with mentoring from Professor David Menon. Now a full professor, Tony has moved to Groningen in Holland where he continues to develop his academic interests. He remains actively involved in UK anaesthesia through the Society for Intravenous Anaesthesia, and research collaborations, as well as serving as a board member of the British Journal of Anaesthesia.

This year the National Institute of Academic Anaesthesia (NIAA) was asked to grant the award on behalf of the College, and I chaired the award committee. We received 11 applications from across the UK. Research proposals covered the full spectrum from 'bench to bedside' and included anaesthesia, pain management and critical care medicine. Methodologies included cell, tissue, animal, patient and population studies – quite a choice.

To help us in the decision making, we sent each application to reviewers in the UK and abroad, with non-clinical scientist referees as well as medics, as appropriate to each proposal. Each proposal was scored by at least five reviewers.

Decision making was structured, democratic and difficult! With such a strong field of applications we could have happily funded at least five had the money been available. Sadly, we had to choose just one, and after much deliberation we selected the submission from Professor Mike Grocott.

Professor Mike Grocott has just been appointed to a chair in anaesthesia at the University of Southampton and is also an honorary Reader in anaesthesia and critical care there. Furthermore, he also leads the NIAA Health Services Research Centre and holds an academic appointment with University College London.

Mike has diverse research interests that include the leadership of the science programme of the Caudwell Xtreme Everest Expedition. His ‘Fit 4 Surgery’ project addresses the association between fitness and surgical outcomes. This application is concerned with the effect of neo-adjuvant chemotherapy.

Neo-adjuvant chemotherapy (NACHemo) is used before many types of major cancer surgery, and may increase the risk of death following surgery. This is probably because NACHemo associated harm to cardio-respiratory fitness increases the risk of postoperative morbidity and mortality which, in some patients, outweighs the beneficial effects of NACHemo mediated tumour regression. This may be particularly true in the proportion of patients in whom tumour regression following NACHemo is limited. Exercise training is known to improve fitness in healthy individuals, patients with heart and lung disease, and in patients prior to major non-cancer surgery. The effect of this improvement of fitness on complications following surgery remains unknown. The mechanisms of NACHemo harm, as well as of training benefit, are also uncertain. The aims of Mike’s programme of research are to:

➤ expand knowledge of the effect of NACHemo on fitness in patients undergoing major cancer surgery across a range of cancer and other operation types

➤ evaluate the benefits (improved patient outcomes) of exercise training prior to major cancer surgery in patients receiving NACHemo

➤ explore, in patients having surgery for cancer, the mechanisms by which NACHemo may be detrimental to fitness, the benefit to fitness from training, and the benefit to outcome from training.

We wish him every success with these projects.
PATIENT SAFETY UPDATE
Including the Summary of Reported Incidents relating to anaesthesia
4 October 2010 to 31 March 2011

THIS DOCUMENT AIMS TO ACHIEVE THE FOLLOWING

➤ Outline which data have been received from whom and when.
➤ Help reporters to understand how their reports are used and therefore encourage improvement in the quality of reported data.
➤ Provide the vignettes with which clinicians can identify and use as learning in their own trusts.
➤ Provide expert comments on reported issues.
➤ Encourage medical staff to contact the Safe Anaesthesia Liaison Group (SALG) in order to share their own learning on any of the incidents mentioned below.

SUMMARY

A total of 5,760 anaesthesia related incidents were reported during the specified time period. 133 incidents were reported using the anaesthetic eForm. 32% of these cases were reported as near miss (harm was prevented from reaching the patient). 40% of incidents reported via the eForm were reported to the National Patient Safety Agency (NPSA) within one day of occurrence.

5,627 incidents were reported using Local Risk Management Systems (LRMS). 19% of these cases were reported as near misses. 50% of incidents reported via LRMS were reported to the NPSA within 38 days of occurrence.

All incidents graded as death or severe were reviewed by the NPSA and, if identified as having potential cause for concern, were reviewed in turn by anaesthetic consultants from the Royal College of Anaesthetists (RCoA) or Association of Anaesthetists of Great Britain and Ireland (AAGBI). This review was carried out in accordance with the NPSA’s data sharing protocol (no information about the trust is disclosed; only information about the incident). Most incidents were reported by consultant anaesthetists, but the eForm is available to all members of the perioperative team.

As with any voluntary reporting system, interpretation of data should be undertaken with caution as the data are subject to bias. Many incidents are not reported, and those which are reported may be incomplete having been reported immediately and before the patient outcome is known. Clarity of ‘degree of harm’ to patients who experience a patient safety incident is an important aspect of data quality.

ANAESTHETIC eFORM

The anaesthetic eForm has been live for use in England and Wales since 30 November 2009. Since the anaesthetic eForm pilot began in May 2008 until 31 March 2011 there have been 741 completed reports submitted. The anaesthetic eForm can be found at: https://www.eforms.npsa.nhs.uk/asbreport.

As a result of the Arm’s Length Bodies review last year, the NPSA will be closing in 2012. Responsibility for the National Reporting and Learning Service (NRLS) will move to the NHS Commissioning Board. SALG would like to reinforce the importance of continuing to report patient safety incidents using the eForm or your local system during the transition so that trends and incidents can be acted upon and learning maximised.

DEGREE OF HARM (ACTUAL INCIDENTS)

Figure 1 shows the degree of harm incurred by patients within the anaesthetic specialty. All of the 16 deaths were reported though LRMS.
Figure 1
Reported degree of harm (actual incidents)

![Degree of Harm](image)

**INCIDENT TYPE**

Figure 2 shows the type of incidents that occurred within the anaesthetic specialty that were reported using LRMS or the anaesthetic eForm. The categories were determined at local level.

**Figure 2**
Type of incident reported

➤ ‘Severe tachycardia in a patient on the ward following elective hip replacement. The hospital has no on-call anaesthetic cover apart from the anaesthetists covering the lists. Patient has been seen by a junior doctor, suspected as acute AF and transferred to accident and emergency department…’

➤ ‘Throat pack not removed at end of operation and swallowed by patient. An abdominal X-ray confirmed the presence of the throat pack in the patient’s stomach. This was removed by endoscopy and the patient was discharged. Trust Patient Safety Team have graded the incident ‘Never Event’.

➤ ‘Child for surgery pre-assessed on inpatient documentation then admitted to day surgery unit on day stay documentation so had two sets applicable to current admission. Given preop oral paracetamol on ward, signed-for on day stay documents. As this had not been specifically requested by anaesthetist was nearly given 2nd dose intra-operatively as working off the alternate set of documents. This type of incident remains a risk where a patient has two sets of documents relating to a single admission all duplicated.’

**SUMMARISED EXAMPLES OF REPORTED INCIDENTS FROM ALL CATEGORIES (REPRODUCED AS RECEIVED)**
‘Elderly patient cancelled from the trauma list for two days. When patient arrived in theatre reception, patient confirmed he had not been given anything to eat or drink for three days previously. Patient was hungry, thirsty and anxious. Staff concerned that he was not in the fittest state to have best surgical results.’

‘Patient stated no movement in his toes or legs – had epidural in situ following bowel surgery. Nursing staff had not recorded motor block. Sensory levels only recorded once since surgery. Patient states couldn’t get out of bed due to no movement – nothing documented in nursing notes.’

‘Called to recovery to see patient with swollen tongue and partial airway obstruction. Decision to check airway and if necessary intubate endoscopically. No fibreoptic bronchoscope available at short notice due to sterilisation issues. Fortunately, able to ventilate with face mask while this was being sorted. Endoscope finally available after 15 minutes. Unacceptable delay with fibreoptic endoscope availability.’

‘SPR anaesthetising for a new list in a different to normal theatre complex. Trainee usually works in cardiac anaesthesia and allocated to general anaesthesia. Having anaesthetised the first patient in the anaesthetic room, moved into theatre where there is a new type of anaesthetic machine that he had not seen... Returns the patient to the anaesthetic room and attempts to familiarise himself with the machine... Still unable to use machine, calls for help. Explanation of machine given (whilst patient is anaesthetised and connected). No further problems for the remainder of the list.’

‘Patient for elective inguinal hernia repair under general anaesthetic. Inadvertently given double the intended dose of gentamicin prophylaxis. Two anaesthetists on list (one consultant, one trainee). 240 mg administered by one anaesthetist shortly after induction. Another dose of 240 mg had been drawn up for the next patient which was then given by the second anaesthetist. The total dose of 480 mg would be a normal therapeutic dose. Electrolytes checked the next day – unchanged from preop.’

‘Patient listed for total hip replacement. Femoral and lateral cutaneous nerve of thigh blocks performed under minimal propofol sedation. Wrong side block performed. Correct site surgery performed. Prior to blocks sign in check performed by ODP whilst anaesthetists out of room. Correct site not reconfirmed by anaesthetists prior to performing block. Neither patient nor ODP corrected anaesthetist till after block performed. Consultant anaesthetist distracted. Moral – being reminded of a problem does not make you immune to the mistake. Make sure you take part in all the theatre process steps required to prevent patient harm. Wrong side block led to less adequate analgesia, otherwise no harm.’

**PARACETAMOL ERRORS IN FOCUS**

54 incidents where paracetamol was used as a keyword were identified within the reports. 39 of these were considered relevant. The themes identified were dosage, communication and variation in policy and some examples are provided below. Please visit the MHRA website for information on a change in paracetamol dosing for children. It is intended that this will prevent repetition of some of the reported issues [www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON123113](www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON123113).

‘Patient had a dose of paracetamol before going to theatre and then was given another dose whilst in theatre. 5th dose in 24 hours.’

‘Patient returned from theatres having received 120 mgs PR paracetamol, equal to 40 mg/kg. Nurses believe that should only have 20 mgs/kg as a single dose. SHO reviewed patient, LFTs checked and ENT Registrar notified. No harm to patient’

‘Patient weighing 3.5 kg given 50 mg of IV paracetamol in theatre. This is double the dose stated in BNF. Paracetamol not given on the ward post op due to double dose given in theatre...’

‘Patient was given the prescribed 1 gram paracetamol on the ward at 8.13 am as part of pre-med. On return to ward after procedure it was noted on the anaesthetic chart that 1 gram of IV paracetamol had been given at 9.30 am...’

‘Staff nurse found that a patient who had returned from theatre had been given 75 mg of diclofenac in the anaesthetic room after having 400 mg of ibuprofen 10.00 am. The patient had also been given paracetamol at 8.00 am and a further dose was then given in the anaesthetic room at 11.20 am. I had clearly documented on the drug chart and in the anaesthetic booklet the doses and the times they were given...’

‘Documentation not completed after administration of paracetamol and Voltarol PR in theatres. Mum present at handover of child in recovery along with another staff nurse. Parents asked when next dose of pain relief could be given; I replied that I could give the patient some immediately as the information document showed nothing had been administered. Mum then advised me she believed that pain relief had been given in theatres... I contacted theatres and spoke to ODP who then contacted the anaesthetist who confirmed this. Paracetamol 250 mg and Voltarol 25 mg were administered PR @ approx 11.30 am by consultant anaesthetist. No further medication given and ward sister/senior Nurse on-call was notified.’

**TIMELINESS OF REPORTING**

Figure 3 shows the timelines of reporting incidents via the anaesthetic eForm (directly received into the NRLS) and via LRMS (uploaded to the NRLS periodically via local systems); that is, the time difference between an incident occurring and the incident being reported to the NPSA.
Safer Administration of Insulin – NPSA Rapid Response Report
SALG has expressed their concern that the NPSA Rapid Response Report ‘Safer Administration of Insulin’ (www.nrls.npsa.nhs.uk/resources/EntryId45=74287) has not been noted widely enough. You are urged to read the Report (published on 16 June 2010) and share with your colleagues. We would also ask for your vigilance for pending guidance.

Brachial Plexus Injury resulting from Patient Positioning During Surgery
Anonymised feedback to SALG can be now be viewed online (www.rcoa.ac.uk/docs/ResponsesANON.pdf). SALG is in the process of engaging with surgical colleagues in order to publish a summary of the main concerns and how to avoid them.

Wrong Site Blocks During Surgery
Following their notification regarding the avoidance of Wrong Site Blocks, SALG received much local learning and feedback. This feedback is now available to view on the SALG website (www.rcoa.ac.uk/wsb). A group of anaesthetists in Nottingham shared a scheme of work entitled Stop Before You Block. With the endorsement of SALG and RA-UK the Group has published a poster for use in all UK hospitals. Please download the poster from the same link.

Poorly Seated Vaporisers
The MHRA has received reports of incidents where the failure to correctly attach vaporisers to the anaesthetic machine back-bar has led to anaesthetic gas leakage and potential patient awareness. This may be more pronounced where vaporisers are attached to anaesthetic machines from an alternative manufacturer. The alert reference is: www.mhra.gov.uk/Publications/Safetywarnings/MedicalDeviceAlerts/CON085024.

Single Use Ampoules
SALG would like to highlight the recent NPSA Signal on the use of single drug ampoules for more than on-patient (www.nrls.npsa.nhs.uk/resources/EntryId45=130185). They would like to remind clinicians that no financial implications should be considered when disposing of ampoules after use, regardless of the remaining drug volume. The only way to prevent cross infection and drug contamination due to use for multiple patients was to recommend that ampoules never be used for more than one patient.

Oxygen Safety in Hospitals – NPSA Rapid Response Report
SALG would like to emphasise the fifth action point of the NPSA Rapid Response: ‘Oxygen Safety in Hospitals’ following concerns raised by clinicians with SALG. It is recommended that: ‘Oxygen is prescribed in all situations in accordance with BTS guidelines (author’s emphasis)…’ The British Thoracic Society guidelines can be accessed via the following link: www.brit-thoracic.org.uk/clinical-information/emergency-oxygen/emergency-oxygen-use-in-adult-patients.aspx.

SALG would also like to remind anaesthetists and other healthcare professionals that patients with unexpected oxygen requirements must receive a medical re-assessment.

Any staff members measuring oxygen saturation using pulse-oximetry need to be aware of the limitations of this method. The MHRA issued ‘Top Ten Tips for pulse oximetry’ with the AAGBI at the end of last year: www.mhra.gov.uk/Publications/Postersandleaflets/CON100224.
Inadvertent Administration of Paralysing Agents
SALG would like to draw clinicians’ attention to the NPSA Alert ‘Residual anaesthetic drugs in cannulae’ following a number of recent reports on this issue (www.nrls.npsa.nhs.uk/resources/?EntryId45=65333).

Spinal and Intrathecal Needle Evaluation Project
In association with the OAA, SALG endorses an evaluation tool for recording opinions, successes and failures in using new equipment in line with the NPSA Alert on Safer Spinal, Intrathecal and Epidural devices. The evaluation form and more information on the project can be found on the OAA website at: www.oaa-anaes.ac.uk/content.asp?contentid=367.

SALG Safety Network and Risk Management Forum
The SALG Safety Network continues to increase in strength and number. All anaesthetists and members of the theatre team are welcome and encouraged to join. SALG is also proud to host a Risk Management Forum for administrative Risk and Patient Safety Managers. It is our experience that a strong relationship between clinicians and risk managers ensures a more robust safety culture and so we urge all risk managers to join. For more information on either of these two groups or to join please email the SALG administrator (salg@rcoa.ac.uk).

SAFE ANAESTHESIA LIAISON GROUP
Patient Safety Conference 2011
Monday, 3 October 2011
The Royal College of Anaesthetists
Fee: £200

The programme will focus on the non-technical skills required to maintain safe practices in anaesthesia, including:

➤ Team working
➤ Situational awareness
➤ Communication skills

To register, go to: www.rcoa.ac.uk/events

Non-Luer Spinal Devices Evaluation – please take part

The Obstetric Anaesthetists Association (OAA), in partnership with the Safe Anaesthesia Liaison Group (SALG), have developed an evaluation system for new spinal (intrathecal), epidural and regional devices. In light of the November 2009 NPSA Alert, and subsequent January 2011 updates requiring a change to non-luer connectors, a number of new products have become, and continue to become available.

OAA and SALG consider specialty input crucial to the ergonomic success of new equipment and urge you to take this opportunity to feed back on new kit. Information on the evaluation and the evaluation form can be found on the OAA website.

Please send all evaluation forms to spinal@rcoa.ac.uk.

Key points on the evaluation project:

➤ The identity of the person submitting the form or their hospital (if included) will not be displayed publicly, although the OAA may request further details in the event that an equipment supplier wishes to comment on or query a specific result.

➤ This evaluation does not replace incident reporting to NPSA or MHRA. Therefore please follow your own and your trust’s normal practice of incident reporting in the event of a patient safety incident resulting from the use of these devices.

➤ If a report has been submitted to MHRA or the NPSA, this must be specified on the OAA return.

➤ Please pass this information on to colleagues.
Report of Council

At a meeting of Council on Wednesday, 15 June 2011, Dr P Nightingale was elected as President for a further year from September 2011. Dr J-P van Besouw was elected Senior Vice-President for one year from September 2011. Professor J R Sneyd was elected Vice-President for one year from September 2011.

The following Fellows were admitted as examiners to the Primary Fellowship Examination of the College:

- Dr M Abdullatif (Stockport)
- Dr L Azavedo (Preston)
- Dr J Donnelly (Dunfermline)
- Dr L Hardy (Stockport)
- Dr S Jaggar (London)
- Dr A Klein (Cambridge)
- Dr A Krishnamurthy (Harlow)
- Dr N Morgan-Hughes (Sheffield)
- Dr S Nagaraja (Liverpool)
- Dr A Ng (Wolverhampton)

Dr A Krol (London) was awarded the Fellowship ad eundem of the College.

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

**Regional Adviser**

**Anglia**
*Dr S Fletcher, Norfolk and Norwich University Hospital NHS Trust*

**Deputy Regional Advisers**

**South Thames East**
*Dr J Curran, Queen Victoria Hospital*

**College Tutors**

**West Yorkshire**
Dr S B Walwyn, Dewsbury District Hospital (in succession to Dr C L Hildyard)

**North West**
Dr N J Pickstock, Lancashire Teaching Hospitals NHS Trust (in succession to Dr K J Kidner)

**South West Peninsula**
Dr A R A Ruston, Derriford Hospital (in succession to Dr T C E Gale)

**South Thames East**
Dr I Ahmed, Guy’s Hospital (in succession to Dr J B Watkiss)

**Sheffield and North Trent**
Dr S Sanghera, Northern General Hospital (in succession to Dr A R Dennis)
Dr E M Wilson-Smith, Sheffield Children’s Hospital (in succession to Dr C M Wilson)

**Head of School**

**Barts and the London School**
Dr E McAteer (in succession to Dr K Wark)

Council noted recommendations made to the GMC for approval, that CCTs/CESR (CP)s 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)s in Anaesthesia and ICM.

**London**

**South East**
Dr Kumaravel Veerappan
Dr Raja Sekhar Reddy Byreddy
Dr Rebecca Helen Mines
Dr Krishna Rajesh Srinivas

**North Central**
Dr Anthony Keith Parsons *
Dr Jason Ayite Cronje
Dr Kwok Mun Woo

**Barts**
Dr Tabitha Anne Tanqueray
Dr Tarannum Rampal

**Imperial**
Dr Tasneem Katawala

**St George’s**
Dr Sumita Saxena

**East Midlands**

**Leicester**
Dr Alison Jayne Brewer
Dr Thomas Edward Cowlam

**Nottingham**
Dr Ruth Mary Longfellow
Dr Lucy Andrew
Dr Melanie Jane Davies
Dr Kathryn Rose Corrie
Dr Tony Derrick O’Leary
Dr Daniel John Robertson Harvey *

**North West**
Dr Rosalind Beth Morley
Dr Abigail Jones
Dr Tom Henry Lupton
Dr Iain Dunn
Dr Claire Elizabeth Moore
Dr Jaya Thakur Nariani
Dr Sailes Kumar Mishra

**Northern Ireland**
Dr Monica Chogle
Dr John Michael McLoughlin
Dr Siobhan Anne Cavanagh

**Oxford**
Dr Kevin David Johnston

**Severn/Bristol**
Dr Kieron Derek Rooney *
Dr Adrian Upex
Dr James Matthew Peyton

**South West Peninsula**
Dr Andrew Murray McEwen

**Tri-Services**
Dr Timothy Charles Nicholson Roberts *

**Wessex**
Dr Matthew Edward Cross
Dr Tamsin Louise Gregory

**West Midlands**

**Stoke**
Dr Ratnayake Mudiyanaselage Athula
Wimal Ratnayake

**Warwickshire**
Dr Matthew John Gray
At a meeting of Council on Wednesday, 20 July 2011, the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

**Regional Advisers**
There are no appointments or re-appointments this month.

**Deputy Regional Advisers**
There are no appointments or re-appointments this month.

**College Tutors**

**Northern**
Dr V J Addison, Freeman Hospital (in succession to Dr M K Weaver)

**West Yorkshire**
Dr P C Jackson, Leeds General Infirmary (in succession to Dr A J Pinder)

**Northern Ireland**
Dr D T Lee, Ulster Hospital (acting Tutor for three months)

**North Thames West**
Dr A Ghori, Royal Brompton Hospital (in succession to Dr S Jaggar)

**North Thames Central**
Dr A M Campbell, The Heart Hospital (in succession to Dr E M C Ashley)

**North West**
Dr M S M Abdullatif, Stepping Hill Hospitals (in succession to Dr L A Hardy)
*Dr R Bhishma, North Manchester General Hospital
*Dr T J Clarke, East Lancashire NHS Trust
*Dr S M Richmond, Royal Lancaster Infirmary

**West of Scotland**
*Dr A G Macfie, Golden Jubilee Hospital

**Wessex**
Dr M H M Jackson, Portsmouth Hospitals NHS Trust (in succession to Dr M C Nixon)
*Dr A P Mackie, Southampton University Hospital

**South Thames East**
Dr H C Statham, Queen Mary’s Hospital (in succession to Dr D J H Lee)

**Leicester and South Trent**
Dr R Ferrie, Kettering General Hospital (in succession to Dr N J W Dunk)

**West Midlands North**
Dr K P Krishnan, Sandwell General Hospital (in succession to Dr N P Carter)

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

The following list of Fellows were approved from the June 2011 sitting of the Final FRCA SOE examination:

- ABU Al-Saad Najwan
- ALLAN John Samuel
- ASTON Daniel Thomas
- ATHANASSOGLOU Vassilis
- AUSTIN Jill
- BADEK Lukasz Lech
- BAILES Ian David Walker
- BANKS Luke
- BARR Rebecca Claire
- BARRON Ann Margaret
- BECK James
- BEVIR Thomas James
- BIDWAI Anita
- BLACK Samantha
- BORGEAU Nathan James
- BOWDITCH Julia Catherine
- BOWEN Lowri
- BOYNTON Claire Ann
- BREEN Thomas Maximillian
- BRIGUE Uvie
- BRISCOE Richard Charles
- BROWN Hannah
- BUCKLEY Aisling Brigid
- BUCHART Angus Gordon
- BYARD Alison Elaine
- CARTER Alison Heather
- CATTLIN Charlotte Stephanie
- CHAKLADAR Abhijoy
- CHEE Nigel Malcolm
- CHELLA Narendran Rajesh
- CHRISTIE Linsey Emma
- CLARKE Victoria Louise
- CLELAND Stuart Robert
- CLEMENTS Joanne Louise
- CLIFF Dominic
- COCKCROFT James Oliver Buchanan
- COLEMAN Simon William
- COLLINSON Catherine Victoria
- COPELAND Rachel
- COULSON Neil Stuart
- COWEN Ruth
- COWIE Patrick Crooks
- CREWS Maryam Nasreen
- CUMMINGS Iain Meggison
- DAUNT Matthew William
- DAVIES Sian Rebecca
- DAVIES Keith Jacob
- DAY James Robert
- DELVE Peter Anthony
- DHARMADASA Asela
- DOLPHIN Thomas Stephen
Deaths

It is with regret that the College records the deaths of those listed below.

Dr S Alstadt, London
Dr D Barran, Glasgow
Dr P Mackenzie, Glasgow
Dr A Peeling, Newport, South Wales
Dr P Challen, Gwynedd

The College is able to receive brief obituaries (of no more than 500 words), with a photo if desired, of fellows, members or trainees. These will be published on the College website (www.rcoa.ac.uk/obituaries) for a period of one year, after which they will be moved to a permanent archive. Please email your text and any photo to: website@rcoa.ac.uk.

Appointment of Fellows to consultant and similar posts

The College congratulates the following fellows on their consultant appointments:

Dr S Chinniah, Darlington Memorial Hospital, County Durham
Dr C E Farrow, Bradford Royal Infirmary
Dr C Moore, University Hospital of South Manchester
Dr K O’Connor, Craigavon Area Hospital, Belfast
Dr D Odedra, St James’ University Hospital, Leeds
Dr G Sivasankara, Royal Victoria Hospital, Belfast
Dr A Thillaisundaram, Frankston Hospital, Peninsula Health, Melbourne, Australia
Dr S Tunstill, Royal Berkshire Hospital
Dr P Warman, Leeds General Infirmary

Appointment of Members, Associate Members and Associate Fellows

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

**Associate Fellows**

**May**
Dr Anne Marie Troy
Dr Ritesh Maharaj
Dr Khorat Uddin Farooq
Dr Ashish Pralhad Gulve
Dr Prasanna N Tilakaratna
Dr Andras Safranko
Dr Ann Carmel Gallagher

**June**
Dr Ammar Keiralla

**July**
Dr Susan Atkinson
Dr Richard Michael Bateman

**Members**

**May**
Dr Yaser Mounir Haggag
Dr Antonio M Marinazzo
Dr Shandar Salam
Dr John Mervyn McBrien

**June**
Dr Bhamini Ramaswamy
Dr Subha Brata Bagchi
Dr Robert Austin Stafford

**July**
Dr Thosa J G Johnson

**Affiliates – Physicians’ Assistants**

**May**
Mr Simon Kennedy
Miss Samantha McColl

**July**
Miss Adele Louise Chinyimba

Bulletin advertising

The Royal College of Anaesthetists’ Bulletin is published bi-monthly and distributed to over 15,000 anaesthetists worldwide, the vast majority being in the UK. Being so widely distributed, it is obviously seen by many other professionals who work alongside anaesthetists. 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, be related to anaesthesia, critical care and pain medicine and will be accepted at the discretion of the Editor or Editorial Board.

Non-commercial advertising rates are listed below and are valid from July 2011. Please see the Bulletin pages of the website for specific commercial rates, deadlines and further information on discounts available.

**Quarter page (85 mm by 124 mm)**
£250 +VAT

**Half page (85 mm by 252 mm)**
£495 +VAT

**Full page (175 mm by 252 mm)**
£795 +VAT

www.rcoa.ac.uk/bulletin
### UK training in emergency airway management

**29–30 September 2011 (code: D29)**  
RCoA, London  
Registration fee: £405  
LIMITED AVAILABILITY

### Patient safety conference 2011

**3 October 2011 (code: C03)**  
RCoA, London  
Registration fee: £200 (£150 for RCoA registered trainees and affiliates)

### CPD study days: supporting you through revalidation

**4–5 October 2011 (code: A99)**  
RCoA, London  
Registration fee: £395 (£295 for RCoA registered trainees and affiliates)

### CPD study day, Belfast

**5 October 2011 (code: C97)**  
Waterfront Hall, Belfast  
Registration fee: £200 (£150 for RCoA registered trainees and affiliates)

### Airway workshop, Glasgow

**12 October 2011 (code: C40)**  
Teacher Building, Glasgow  
Registration fee: £250 (£190 for RCoA registered trainees and affiliates)

### Ultrasound workshop

**18 October 2011 (code: D09)**  
RCoA, London  
Registration fee: £230 (£175 for RCoA registered trainees and affiliates)

### UK training in emergency airway management, Edinburgh

**26–27 October 2011 (code: B75)**  
Royal Infirmary, Edinburgh  
Registration fee: £405  
LIMITED AVAILABILITY

### A career in anaesthesia

**1 November 2011 (code: C49)**  
RCoA, London  
Registration fee: £35

### Current concepts symposium 2011: Anaesthesia and critical care

**3–4 November 2011 (code: B05)**  
RCoA, London  
Registration fee: £425 (£320 for RCoA registered trainees and affiliates)

### CME day

**5 November 2011 (code: A76)**  
RCoA, London  
Registration fee: £230

**REDUCED RATE**  
Current Concepts Symposium 2011/CME day 2011  
A reduced rate of £535 (£420 for RCoA registered trainees and affiliates) has been introduced for those attending both the Current Concepts symposium and the CME day meeting. Places for the events will be offered on a first come first served basis.

### Anaesthetists as educators: an introduction

**9 November 2011 (code: A12)**  
RCoA, London  
Registration fee: £210 (£160 for RCoA registered trainees and affiliates)

### Acute pain medicine: hot topics

**11 November 2011 (code: A78)**  
RCoA, London  
Registration fee: £155 (£125 for RCoA registered trainees and affiliates)

### Research methodology workshop

**15 November 2011 (code: C43)**  
RCoA, London  
Registration fee: £140  
LIMITED AVAILABILITY

### Airway workshop

**16 November 2011 (code: C65)**  
RCoA, London  
Registration fee: £250 (£190 for RCoA registered trainees and affiliates)

### Joint Clinical Directors’ day

**17 November 2011**  
RCoA, London  
By invitation only

### Recent advances in anaesthesia, critical care & pain management

**22–24 November 2011 (code: C11)**  
The Lowry, Manchester  
Registration fee: £470

### Advanced central venous access for anaesthetists

**7 November 2011 (code: F35)**  
RCoA, London  
Registration fee: £230 (£175 for RCoA registered trainees and affiliates)  
LIMITED AVAILABILITY
AIRWAY WORKSHOPS

Date and venue:
12 October 2011, Glasgow (code: C40)
16 November 2011, London (code: C65)
1 February 2012, London (code: B53)
7 March 2012, Cardiff (code: C96)

Registration fee:
£250 (£190 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

Event organisers:
Dr R Bhagrath, Dr T Turley, Dr A McNarry and Dr V Cunningham
LIMITED AVAILABILITY

Previous workshops have proved to be very popular – early booking is advised.

The RCoA Airway Workshops are an opportunity to gain hands-on practice with airway equipment and teaching in core airway skills from experienced consultants. Appropriate for all grades of anaesthetists from CT1 to consultants. Topics covered include:

- Fibreoptic handling skills and techniques for awake FOI (2A01)
- Uses of new/established supraglottic airways (IC02)
- Rescue techniques including cricothyrotomy (2B02)
- Extubation, follow-up and case scenarios (IC01 +2)
- Video laryngoscopy (IC01 IC02 2A01)

Teaching and practice are conducted in small groups with six to eight workshops.
ANNIVERSARY MEETING 2012
QUALITY AND OUTCOME IN ANAESTHESIA

Date and venue:
14–15 March 2012 (code: A03)
Royal Institute of British Architects, 66 Portland Place,
London W1B 1AD

Registration fee:
£425 (£320 for RCoA registered trainees and affiliates)
Approved for 10 CPD credits

Event organiser:
Dr J Hardman

Day 1

9.00 am
Registration and refreshments

9.30 am
Welcome and introduction by
Dr P Nightingale, President, RCoA

SESSION 1: AVOIDING ERRORS

Checklists: do they improve outcome? (1F01 1I03)
Speaker to be advised

Drug errors in anaesthesia (1I01 1I03)
Speaker to be advised

SESSION 2: IMPROVING OUTCOME

Guidelines for anaesthetic care: support or constraint? (1I02 1I03)
Dr A Smith, Lancaster

Evidence-based medicine (1G02 3J00)
Dr A Moller, Denmark

SESSION 3

CLOVER LECTURE
Evidence, research and all that stuff
Dr S Yentis, London

2.05 to 2.25 pm
RCoA Annual General Meeting

AWARD OF THE COLLEGE MEDAL
Dr T Clarke, Newcastle

SESSION 4: QUALITY TEAMS

Modern anaesthesia training: is it good enough? (1I03)
Dr A McIndoe, Bristol

Communication and team-working (1I03)
Speaker to be advised

Delegation and non-medical providers of anaesthesia (1I02)
Speaker to be advised

5.20 pm
Close of meeting followed by a drinks reception

Day 2

8.40 am
Registration and refreshments

SESSION 5: ASSURING QUALITY

Measuring and recording outcome (1I05)
Speaker to be advised

Using quality indicators in anaesthesia (1I05)
Dr J Benn, London

Is a consultant-delivered service feasible or desirable? (1I02 1I03)
Dr W Harrop-Griffiths, London

SESSION 6: LITIGATION AND CONSENT

Lessons from litigation (1F01 1I04 1I05)
Speaker to be advised

Is ‘informed’ consent possible? Is it desirable? (1F01)
Dr S White, Brighton

SESSION 7: CONTROVERSIES IN QUALITY CARE

Epidurals for elective surgery (2G01 1F01)
Speaker to be advised

Regional anaesthesia for all (2G01 1F01)
Speaker to be advised

Intra-operative fluid infusions: how much is too much? (2A05 1I05)
Professor D Buggy, Dublin

SESSION 8: HIGH RISK SURGERY

Assessing fitness and predicting outcome (1F01 2A03)
Dr J Carlisle, Torquay

Paediatric cardiac anaesthesia: balancing risk and outcome (3G00 3D00 1I0)
Professor A Wolf, Bristol

4.35 pm
Refreshments and trade exhibition to close
RECENT ADVANCES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

Date and venue:
22–24 November 2011 (code: C11)
The Lowry, Pier 8, Salford Quays, Manchester M50 3AZ

Registration fee:
£470
Approved for 15 CPD credits

Event organisers:
Dr D Nolan and Dr J Goodall

Day 1
- 9.00 am
  Registration and refreshments
- Which bugs, which drugs? Infection control in the critically ill
  Dr A Colville, Exeter
- Setting up a CPEX service: how to go about it
  Dr O Pratt, Salford
- Perioperative CVS monitoring: what should we be using and when?
  Dr J Langton, Plymouth
- New airway devices
  Dr E O’Sullivan, Dublin
- The difficult paediatric airway
  Dr R Walker, Manchester

Day 2
- 8.30 am
  Registration and refreshments
- Anticoagulation in the perioperative period
  Dr P Erasmus, Plymouth
- Serious hazards of transfusion
  Dr A Copplestone, Plymouth
- Anaesthesia and critical care management of the Jehovah’s witness
  Professor M Bellamy, Leeds
- Transdermal delivery: an ideal way to treat chronic pain?
  Dr B Bradner, London
- Analgesia for abdominal surgery: epidural or abdominal wall blocks?
  Dr J Yarwood, Dewsbury
- ICM management of the patient with...
  Burns
  Professor J Kinsella, Glasgow
  Severe hypoxia
  Dr B Winter, Nottingham
  Renal failure
  Dr R Challiner, Manchester
- Neuraxial anaesthesia: is it safe and does it help?
  Speaker to be advised

Day 3
- 9.00 am
  Registration and refreshments
- How I manage subarachnoid haemorrhage
  Dr R Protheroe, Manchester
- How to manage the ruptured aortic aneurysm
  Professor J Thompson, Leicester
- Infection detection
  Dr P Dark, Salford
- Minimalising catheter related infections
  Dr S Fletcher, Bradford
- Current management of atrial fibrillation
  Dr E Rowland, London
- Preparing for the inevitable inquest
  Dr D Bogod, Nottingham
- What do IMCAs add to ICM practice?
  Dr A Batchelor, Newcastle
- 3.00 pm
  Close of meeting

DEBATE
- All acutely ill patients should be given 100% oxygen
  Speaker to be advised
- Against
  Dr A Lumb, Leeds
CURRENT CONCEPTS SYMPOSIUM 2011: ANAESTHESIA AND CRITICAL CARE

**REduced rate**

Current Concepts Symposium 2011/Continuing Medical Education (CME) day 2011

A reduced rate of £325 (£250 for RCoA registered trainees and affiliates) has been introduced for those attending both the Current Concepts symposium and the CME day meeting. Places for the events will be offered on a first come first served basis.

### Day 1
- **9.00–9.30 am**
  - Registration and refreshments
- **Welcome and introduction**
  - Dr P Nightingale, President, RCoA
- **SESSION 1: BEST PERIOPERATIVE CARE**
  - CHAIR: DR A TOMLINSON
    - **Before**
      - Dr J Carlisle, Torbay
    - **During**
      - Professor M Mythen, London
    - **After**
      - Dr R Pearse, London
- **SESSION 2: CLINICAL ANAESTHETIST AND ACADEMIA**
  - NAP4 and the future of national audit projects
    - Dr T Cook, Bath
  - The NIACC Health Services Research Centre
    - Dr M Grocott, London
- **SESSION 3: PERIOPERATIVE MEDICINE**
  - CHAIR: DR P NIGHTINGALE
    - MACINTOSH LECTURE
      - What is the role of urotensin in cardiovascular disease?
        - Professor J Thompson, Leicester
    - Perioperative beta blockade
      - Dr G Ackland, London
    - Big is best? Perioperative risk associated with obesity and nutritional deficiency
      - Dr J Holding, London

### Day 2
- **SESSION 4: INNOVATION IN EDUCATION AND HEALTHCARE**
  - CHAIR: DR S PATEL
    - The HeartWorks TOE training tool
      - Dr S Wright, London
    - Re-inventing the wheel: novel laryngoscopes
      - Dr A Patel, London
    - Developing your innovation into reality
      - Dr J Roberts, London
    - Drinks reception

### Day 3
- **SESSION 5: ETHICS AND THE LAW**
  - CHAIR: PROFESSOR R K MIRAKHUR
    - Organ donation
      - Dr P Murphy, Leeds
    - Ethics and the intensivist
      - Professor J Bion, Birmingham
    - The anaesthetist and the law
      - MPS representative, London

### Day 4
- **SESSION 6: ANAESTHESIA AND ANALGESIA: LEAVING INHALATIONAL AGENTS BEHIND**
  - CHAIR: PROFESSOR J BION
    - Optimising perioperative pain management
      - Dr I Christie, Plymouth
    - Peripheral nerve blockade
      - Professor V Chan, Toronto
    - **1.00–1.45 pm**
      - PRESENTATION OF COLLEGE PRIZES

### Date and venue:
- **3–4 November 2011 (code: B05)**
- Royal College of Anaesthetists, London

### Registration fee:
- £425 (£320 for RCoA registered trainees and affiliates)
- Approved for 10 CPD credits

### Event organiser:
- Dr Ramani Moonesinghe

**Reduced rate**

Current Concepts Symposium 2011/Continuing Medical Education (CME) day 2011

A reduced rate of £325 (£250 for RCoA registered trainees and affiliates) has been introduced for those attending both the Current Concepts symposium and the CME day meeting. Places for the events will be offered on a first come first served basis.
## CME DAY

Professor Chandra Kumar has reproduced the 2009 format for the CME Day programme comprising 18 lectures, allowing participants to choose a total of six lectures themed around what is new in improving clinical outcomes, critical incidents and anaesthetic management of various surgical procedures.

### Date and venue:
5 November 2011 (code: A76)
Royal College of Anaesthetists, London

### Registration fee:
£230
Approved for 5 CPD credits

### Event organiser:
Professor C Kumar

<table>
<thead>
<tr>
<th>Session 1: Improving Outcome</th>
<th>Session 2: Practice Guidelines</th>
<th>Session 3: What is New?</th>
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</thead>
</table>
| A. Improving outcome after colorectal surgery  
Dr S Nimmo, Edinburgh | B. Paediatric emergencies in the DGH  
Dr M Tremlett, Middlesbrough | C. Improving outcome in the intensive care: Lessons from ICNARC  
Dr S Bonner, Middlesbrough |
| B. Paediatric emergencies in the DGH  
Dr M Tremlett, Middlesbrough | C. Controversies in sedation practice: The role of the anaesthetist  
Dr A Tomlinson, Stoke on Trent | C. Thromboprophylaxis – targets and best practice  
Dr S Renwick, London |
| Session 3: What is New? | Session 4: Critical Incidents | Session 5: Anaesthetic Management |
| A. Advances in nerve locations during regional anaesthesia  
Dr B Nicholls, Taunton | B. Acute pain management and major lower limb surgery  
Dr B Fischer, Redditch | A. Management of obese obstetric patient  
Dr W Scott, Derby |
| Session 4: Critical Incidents | Session 5: Anaesthetic Management | B. Anaesthetic management for major laparoscopic surgery  
Professor A Cunningham, Dublin |
| A. Patient safety – where is RCoA heading?  
Professor R Mahajan, Nottingham | B. Allergic reactions during anaesthesia  
Dr N Harper, Manchester | C. Anaesthesia for maxillofacial trauma and sepsis  
Dr J Curran, East Grinstead |
| Session 6: Ups and Downs in Clinical Practice | Session 6: Ups and Downs in Clinical Practice | Session 6: Ups and Downs in Clinical Practice |
| A. Pain management during labour  
Dr D Hill, Belfast | B. Lessons from NAP4  
Dr T Cook, Bath | C. Regional anaesthesia: the ups, the downs and the backup plans  
Dr W Harrop-Griffiths, London |

### Schedule
- **9.00 am**
  - Registration and refreshments
- **Introduction for all delegates**
  - Dr P Nightingale, President, Royal College of Anaesthetists

**Delegates may choose one lecture per session**

**Session 1: Improving Outcome**
- A. Improving outcome after colorectal surgery
  - Dr S Nimmo, Edinburgh
- B. Paediatric emergencies in the DGH
  - Dr M Tremlett, Middlesbrough
- C. Improving outcome in the intensive care: Lessons from ICNARC
  - Dr S Bonner, Middlesbrough

**Session 2: Practice Guidelines**
- A. Regional anaesthesia and anticoagulated patients: ASRA guidelines
  - Professor V Chan, Toronto
- B. Controversies in sedation practice: The role of the anaesthetist
  - Dr A Tomlinson, Stoke on Trent
- C. Thromboprophylaxis – targets and best practice
  - Dr S Renwick, London

**Session 3: What is New?**
- A. Advances in nerve locations during regional anaesthesia
  - Dr B Nicholls, Taunton
- B. Acute pain management and major lower limb surgery
  - Dr B Fischer, Redditch
- C. Continuous spinal anaesthesia
  - Professor C Kumar, Singapore

**Session 4: Critical Incidents**
- A. Patient safety – where is RCoA heading?
  - Professor R Mahajan, Nottingham
- B. Allergic reactions during anaesthesia
  - Dr N Harper, Manchester
- C. Root cause analysis of major incidents
  - Dr J Shaw, Manchester

**Session 5: Anaesthetic Management**
- A. Management of obese obstetric patient
  - Dr W Scott, Derby
- B. Anaesthetic management for major laparoscopic surgery
  - Professor A Cunningham, Dublin
- C. Anaesthesia for maxillofacial trauma and sepsis
  - Dr J Curran, East Grinstead

**Session 6: Ups and Downs in Clinical Practice**
- A. Pain management during labour
  - Dr D Hill, Belfast
- B. Lessons from NAP4
  - Dr T Cook, Bath
- C. Regional anaesthesia: the ups, the downs and the backup plans
  - Dr W Harrop-Griffiths, London

- **3.35 pm**
  - Close of meeting
FOURTH ANNUAL MEETING
FOR FELLOWS AND MEMBERS, PAIN MANAGEMENT IN SPECIAL SITUATIONS

Date and venue:
30 November 2011 (code: B08)
Royal College of Anaesthetists, London

Registration fee:
£175 (£125 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

Event organiser:
Dr S Gupta

The Annual Meeting serves as an important general update for our Fellows and Members, focusing on the current headlines in pain medicine such as guideline development and acute pain services.

- Chronic pain in paediatrics
  Dr R Howard, London

- Pain persists despite high dose opioid – what to do?
  Dr C Stannard, Bristol

- Pain management in victims of conflict
  Dr D Aldington, Oxford

ACUTE PAIN MEDICINE: HOT TOPICS

Date and venue:
11 November 2011 (code: A78)
Royal College of Anaesthetists, London

Registration fee:
£155 (£125 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

Event organiser:
Dr S Gupta

- TAP block and Q pain busters/local anaesthetic infusions in pain management
  Speaker to be confirmed

- Opioid PCA vs epidural – balance of evidence
  Dr S Kannan, Birmingham

- CRPS – is surgery on affected limbs always contraindicated?
  Dr J Valentine, Norwich

- Chronic pain after surgery – who is at risk?
  Dr J Quinlan, Oxford

- Acute pain management in patients with chronic pain
  Dr S Kapur, Birmingham

- Acute pain in patients with cancer
  Dr L Lynch, Leeds

- Chronic pain post-regional block – does ultrasound make a difference?
  Speaker to be confirmed

- Pre-emptive analgesia – balance of evidence
  Dr K Kyriakides, Bradford

- 4.10 pm
  Close of meeting
CPD STUDY DAY, BELFAST

Date and venue:
5 October 2011 (code: C97)
The Waterfront, Belfast

Registration fee:
£200 (£150 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

Event organiser:
Dr B Darling

- 8.45–9.15 am
  Registration and refreshments
- 9.15 am
  Welcome and introduction by Dr P Nightingale, President, RCoA
- The Difficult Airway Society ADEPT approach to evaluating novel airway devices (2A01)
  Dr J Pandit, Oxford
- Quality improvement in healthcare (1I05)
  Dr D Hill, Belfast
- Preoperative assessment tools (2A03)
  Dr C Russell, Belfast
- Management and investigation of anaphylaxis (1B01)
  Dr M Shields, Belfast
- Perioperative management of diabetes mellitus (2A06)
  Dr B J Watson, King’s Lynn
- The dangers of the job to our health (3J00)
  Dr J Down, London
- How to write (or read) a scientific paper: what do editors look for? (1G02)
  Dr J Pandit, Oxford
- The Northern Ireland Advisory Board
  Dr B Darling, Belfast
- 4.00 pm
  Close of meeting

ADVANCED CENTRAL VENOUS ACCESS FOR ANAESTHETISTS (HICKMANS, PICCS AND PORTS)

Date and venue:
7 November 2011 (code: F35)
Royal College of Anaesthetists, London

Registration fee:
£230 (£175 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

Event organisers:
Dr A Bodenham and Dr A Johnston

- Provision of long term access, Service models, funding
- Choice of devices, patient assessment, sedation/LA/GA?
- Catheter tip positioning
- Central Venous access in the very small child
- Common problems. Blocked catheter management. Fibrin sleeves, mechanical blockage, fibrinolytics

RESEARCH METHODOLOGY WORKSHOP

Date and venue:
15 November 2011 (code: C43), 13 March 2012 (code: D39), 28 May 2012 (code: C85)
Royal College of Anaesthetists, London

Registration fee:
£140
Approved for 5 CPD credits
CPD Matrix coding: 3J00

Event organiser:
Professor P Hopkins

A joint workshop with the British Journal of Anaesthesia to introduce participants to the way in which good research should be conducted and presented.
The workshop will be useful for anaesthetists of any grade who are already involved in research or those who are about to embark on a research project.
Topics include:
- Developing an Idea
- Critique of published research paper
- Study design
- Design a clinical trial
- Dissemination of results
Group sessions will allow participants to: provide criticism of a published research paper; design a clinical trial; detect common pitfalls in analysis and interpretation of data.
Please complete this form in BLOCK CAPITALS and return to the Finance Department at the RCoA or via fax (020 7092 1733).

Terms and conditions
- Additional copies of this form can be downloaded from www.rcoa.ac.uk/docs/meetings.pdf.
- Members of the Senior Fellows Club can attend events at half price.
- Bookings will be accepted on a first come, first served basis.
- Please be aware that programmes are subject to change and you should check the College website for regular updates.
- Our events are open to all grades of anaesthetists, unless specifically stated otherwise.
- When an event is full, this will be publicised on the website. To be placed on a waiting list, please contact the Events Department on 020 7092 1670. We will then contact you as soon as a place becomes available.
- All of our events have CPD approval of five credits for a full day and three credits for a half day, with the exception of FRCA revision courses, which carry a maximum of 15 credits, for non-trainees only.
- Lunch is included in the registration fee unless otherwise indicated.

Booking and payment
- Bookings will be accepted by post or fax only on a first come, first served basis.
- Bookings will not be accepted unless the appropriate fee and application are received together.
- Please note that places are not reserved until payment is received.
- Confirmation of a place will be sent to you within 14 days of payment being received. If you do not receive this, please contact the Events Department.

Cancellation policy
- Notice of cancellation must be given in writing to the Events Department or by email to: events@rcoa.ac.uk at least ten working days prior to the event to qualify for a refund.
- All refunds are made at the discretion of the College and are subject to the deduction of an administration fee.
- Delegates cancelling less than ten days before the event will not be entitled to a refund.
- The College will accept name changes for attendees; please inform the Events Department seven days prior to the event.
For advice on implementation, please visit www.rcoa.ac.uk/wsb
Applications are now invited for Foundation Fellowship of the Faculty of Intensive Care Medicine (FICM).

Applicants for Foundation Fellowship must be substantive UK consultants with a sessional commitment to Intensive Care Medicine. Applicants must also be in good standing with one of the FICM parent Colleges.

Applications for Foundation Fellowship will be accepted from 1 January to 31 December 2011.

Other categories of membership, including those for trainees, are currently under development and will be announced during 2011.

An application form, along with further information on the application process and Fellowship criteria, can be found on the FICM website. Please read these criteria carefully before applying.

www.ficm.ac.uk
Northern Schools of Anaesthesia

Final FRCA Viva Course

Education Centre, The James Cook University Hospital, Middlesbrough

A two-day intensive course

31 October to 1 November 2011
14–15 May 2012

Course Directors: Dr E Kothmann and Dr N Cree

Day 1 – Lectures and Interactive sessions centring on data interpretation

Day 2 – Mock Vivas

Programme aimed at providing full exam conditions for viva experience, advice from examiners and targeted teaching for the exam. One to one feedback given.

Non-residential Course fee: £250 (lunch and refreshments provided)

For further information please contact:
nicola.cree@stees.nhs.uk or elke.kothmann@stees.nhs.uk

The Department of Academic Anaesthesia, Cheriton House, The James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW (01642 854601).

PLACES LIMITED TO 12 CANDIDATES.

Northern Schools of Anaesthesia

Final FRCA Written Paper Crammer Course

The James Cook University Hospital, Middlesbrough

30 January to 1 February 2012

Focusing on MCQs, Single Best Answers, and Short Answer Questions

Programme includes full mock exam, and tutorials covering current ‘hot topics’

Fee: £300

For further information please contact:
nicola.cree@stees.nhs.uk
elke.kothmann@stees.nhs.uk

The Department of Academic Anaesthesia, Cheriton House, The James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW 01642 854601
FRCA Examinerships 2012–2013

The College invites applications for vacancies to the Board of Examiners in the Fellowship of the Royal College of Anaesthetists, for the academic year 2012–2013. 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 the following person specification:

**a Essential**

1. Shall normally be a Fellow by examination, but a Fellow ad eundem, or a Fellow by election of the Royal College of Anaesthetists will also be considered.
2. Shall be in good standing with the College.
3. Applicants must be able to demonstrate that they have the competence, confidence and credibility to assess the next generation of consultants.
4. Shall currently be active in clinical practice in the NHS or a comparable post.
5. On 1 September 2012 shall have the expectation of completing ten years as an examiner whilst filling a Specialty Doctor/SAS grade or consultant appointment in the NHS, or comparable post.
6. Can demonstrate active involvement in the training and assessment of trainees.
7. Good written and verbal communication skills.
8. Ability to work as part of a team.
9. Documentary evidence of satisfactory completion of Equal Opportunities training in the last five years.
10. Able to commit to long-term and active involvement to examiner duties including the ability to devote a minimum of 15 days per academic year to the role. This includes both the delivery and development of the examinations.

**b Desirable**

1. Shall demonstrate a special interest(s) directly relevant to the balance of expertise required in the Board of Examiners.
2. Within the past five years shall have visited a Primary or Final FRCA examination.

Application forms and information for applicants can be downloaded from the examinations section of the College website (www.rcoa.ac.uk/examinations).

Or can be obtained from Miss Chloe Scrivener, Training and Examinations Directorate by tel: 020 7092 1525 or email: cscrivener@rcoa.ac.uk.

The closing date for receipt of completed application forms is Friday, 14 October 2011.
11th Annual Education Day
Paediatric Anaesthesia

RISK REDUCTION IN PAEDIATRIC ANAESTHESIA

Monday, 14 November 2011
The Great Hall, St Bartholomew’s Hospital,
London EC1

A day of lectures, short presentations and debates
for anaesthetists and allied professionals with an
interest in paediatric anaesthesia and critical care.

Awarded 5 CPD credits by the RCoA

Fee: £100 (medical); £15 (non-medical); including
lunch and refreshments

Programme
➤ Risk in paediatric pain
➤ Drug administration errors
➤ Day-case anaesthesia
➤ Paediatric regional techniques
➤ The WHO checklist
➤ URTI and elective paediatric GA
➤ Explaining risk to children and parents
➤ PICU retrieval and risk adversity
➤ The sick neonatal laparotomy
➤ Day case anaesthesia in children – always risk-free?
➤ Simulation in paediatric anaesthesia
➤ Paediatric resuscitation – updates

Faculty
➤ Dr Jim Steven, Attending Anesthesiologist, Children’s
Hospital of Philadelphia
➤ Dr Scott Cook-Sather, Attending Anesthesiologist, Children’s
Hospital of Philadelphia
➤ Dr Walid Habre, Consultant Paediatric Anaesthetist, Geneva
➤ Dr Kathy Wilkinson, Consultant Paediatric Anaesthetist,
Norwich, President APA
➤ Dr Tony Moriarty, Consultant Paediatric Anaesthetist,
Birmingham Children’s Hospital
➤ Dr Steve Roberts, Consultant Paediatric Anaesthetist, Alder
Hay Children’s Hospital
➤ Dr Dan Lutman, Consultant Paediatric Anaesthetist, Barts
and The London Children’s Hospital and Director of CATS
➤ The paediatric anaesthetists, Barts and The London
Children’s Hospital

Application forms and further details from: Nicola Palmer, Course
Administrator, Medical and Dental Education Department,
Postgraduate Centre, 48 Ashfield Street, Royal London Hospital,
London E1 2AJ tel 020 7377 7760 fax 020 7377 7187
email Nicola.Palmer@bartsandthelondon.nhs.uk
THE INTENSIVE CARE SOCIETY
New venue, New 3 day format

The State of the Art Meeting 2011
Monday 12th to Wednesday
14th December 2011

The ICC, East Excel, London
Register now for the largest ICS meeting ever held in the UK featuring:

- A 4-track parallel programme over 3 days dedicated to cutting edge topics in intensive care medicine
- International medical experts, renowned academics and keynote speakers
- Sessions on ALI, Current Practice, ECMO, Ethics, Genomics, Monitoring, Neurosciences, Radiology, Sepsis and Ventilation
- Clinical skill updates from SuBICU, EpaNIC, Optimus,Param Staff and Cardwell
- Everest
- Joint sessions with the ESICM, ISF, BTS Care Group and The UK and Ireland ALI Group
- Research and Clinical Practice free paper presentations, including the prestigious Research Gold Medallion Award
- Training, Nurse and AHP dedicated sessions including The Cadet programme, with your chance to win an iPad 2
- Media screening for medical professionals
- A full trade exhibition showcasing all the latest developments from industry

Celebrating over 40 years of The Intensive Care Society with 50 key opinion leaders

Further details are available at www.ics.ac.uk or by emailing events@ics.ac.uk

follow us @CISMeeetings

ANNUAL CONGRESS
Edinburgh International Conference Centre
21-23 September 2011

- Scientific programme
- Multiple streams of didactic lectures
- Satellite symposia and industry lectures
- Practical workshops
- Technical exhibition
- Annual dinner and dance

www.annualcongress.org

14th Anaesthesia, Critical Care and Pain Forum
On Board: The Algarve
Portugal
26 - 29 September 2011

doctorseupdates.com
Primary Courses 2011/12

- OSCE Weekend 9-11 Sept. 2011
- Viva Weekend 23-25 Sept. 2011
- OSCE Weekend 9-11 Dec. 2011
- Viva Weekend 16-18 Dec. 2011
- OSCE/Onges 6-12 Jan. 2012
- OSCE/Onges 4-11 May 2012
- MCQ 19-25 May 2012

Final Courses 2011/12:

- Final Viva Session 09 Oct - 3 Nov. 2011
- Booker & Fee - 2 Mar. 2012

THE SELECTIVE COURSE

The difficult and poorly understood parts of the FRCA Syllabus made straightforward by a Consultant-led Faculty of Anaesthetists, each a subject matter expert in the topic.

Places are available for external candidates planning to take the Primary MCQ in June 2012. Mersey Deanery candidates are all encouraged to attend.

THE TEACHING:

Didactic lectures, followed by discussion.
Handouts.
8 or more topics per day.
Daily MCQ paper.

THE EVERYDAY:

- Physics
- Breathing and Respiration
- Renal Physiology

THE DIFFICULT:

- Metabolism
- Compounding (for the uninterested)
- Pharmacodynamics (made easier)
- Pharmacokinetics (made fun)

THE POORLY UNDERSTOOD:

- Statistics (to persuade the examiners)
- Acid Base (and strong ions)
- Extreme Physiology (Diving and Mountaineering)

The week long course (19–25 March) will be held at The Liverpool Medical Institute in Central Liverpool. Lunches and refreshments will be included.
How Low Can You Flow?

The Protra anesthesia machine is well equipped to utilize less and normal flow anesthesia and all positive-in压ur gas conditions, reduced impact on the environment and the potential for lower costs on medication agents.

In addition to the best breath breathing system, integrated hepa filter and precision electronic gas delivery, all dispensers for low and normal flow anesthesia:

- The Protra has a unique low flow system, the Proventor. This system is reducing gas losses only with a visual indicator to show the quantity of gas in the system.
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<tr>
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<th>Name</th>
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<tbody>
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## Chief Executive's Office

<table>
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## Education Directorate

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## Professional Standards Directorate

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<td>Press enquiries</td>
<td></td>
<td><a href="mailto:media@rcoa.ac.uk">media@rcoa.ac.uk</a></td>
<td>020 7092 1692/1693</td>
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<tr>
<td>Website</td>
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## Training and Examinations Directorate

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<tr>
<th>Role</th>
<th>Name</th>
<th>Email</th>
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<tr>
<td>Examinations Manager</td>
<td>Graham Clisnett</td>
<td><a href="mailto:exams@rcoa.ac.uk">exams@rcoa.ac.uk</a></td>
<td>020 7092 1525/1526</td>
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<tr>
<td>Training Manager</td>
<td>Craig Williamson</td>
<td><a href="mailto:training@rcoa.ac.uk">training@rcoa.ac.uk</a></td>
<td>020 7092 1552/1553/1554</td>
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<tr>
<td>e-Portfolio Project Manager</td>
<td>Lorna Kennedy</td>
<td><a href="mailto:e-portfolio@rcoa.ac.uk">e-portfolio@rcoa.ac.uk</a></td>
<td>020 7092 1551</td>
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<tr>
<td>Equivalence</td>
<td></td>
<td><a href="mailto:equivalence@rcoa.ac.uk">equivalence@rcoa.ac.uk</a></td>
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<tr>
<td>Intensive care medicine (adult and paediatric)</td>
<td></td>
<td><a href="mailto:ficm@rcoa.ac.uk">ficm@rcoa.ac.uk</a></td>
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<tr>
<td>International Programme</td>
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<td><a href="mailto:ip@rcoa.ac.uk">ip@rcoa.ac.uk</a></td>
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<tr>
<td>Regional Adviser and College Tutor appointments</td>
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<td>SAS and Specialty Doctors</td>
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<td>Quality Assurance</td>
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