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From the Editor

Welcome to 2013, by the time you read this one or two of you may have already been revalidated for the first time. Most of us, though, will still be waiting in anticipation. Revalidation has had a very long gestation and Richard Marks, our guest editor for this edition, explains in detail where we have come from and where we are going. This edition includes a number of supporting articles covering such issues as outcome measures, patient feedback, managing your CPD records online, the College revalidation helpdesk, and mentoring.

Inevitably our President has commented on revalidation in his opening statement but he also discusses medical leadership and the continuing concern about the lack of engagement of clinicians in the medical leadership agenda. Irene Dalton, who is Chairman of our Patient Liaison Group and a retired headmistress, has written an inspirational account of her personal view of what makes a leader. Do read this and reflect on it. It includes some invaluable advice.

Another theme raised by the President is engagement with the media. Si Scott is the College Media Advisor and gives us some fascinating insight into how the media responds to health related news stories.

Dr Hebbes and Briggs tell us about their experience combining part time ACCS training with an education Fellowship. Is it too early to be learning to teach? Read their article and make up your own mind. If you are concerned about the difficulty coping with additional flexible trainees on the rota Dr Taylor gives us advice as to how to meet such a challenge. Meanwhile continuing the theme of younger members of the Fellowship baffling some of us older members with the advancement of portable electronics, Drs Spong, Shonfield and West introduce us to cloud computing technology.

Drs Quinn and Cohen raise the profile of maternal critical care and put forward a strong case for anaesthetists to take control and raise the standards. If this is not convincing enough do read the personal report of Dr Lowrey’s experiences. We all know that young fit obstetric patients can compensate until very late. A real take home message from her is that although early warning scores are important they are not perfect and do not replace the need for history taking and examination.

In the Bulletin 75 we had a series of articles from trainees and trainers reflecting on the Annual Review of Competence Progression (ARCP) process. A recurrent theme was concerns about the process becoming electronic with the development of the trainee e-portfolio. South East Scotland Deanery have always been at the forefront of the development of the e-portfolio so it is not surprising that they are leading in developing a paperless ARCP process and so we asked for feedback from their experiences, which I hope will be of value to you all.

In the Bulletin 70 Andrew Morley discussed exciting plans for an exhibition at the Science Museum. The working title was ‘Sense Less’. Over the year this has metamorphosed into ‘Pain Less’ as a result of public engagement. The exhibition is now live and we sent Dr Reddi to review the result for us.

Finally I would like to say thank you to Dr Roger Laishley who has written articles, from the SAS perspective, for many years in his role as an elected member of council. This will be his last article for the Bulletin just as it will be my last editorial report as we both demit office in the New Year. I would also like to thank Mandie Kelly and Anamika Trivedi, who have provided me with outstanding support over the last twelve months. This journal could not exist without them. I am handing over the role to Nigel Penfold and I am sure that he will enjoy the challenge as much as I have, with such an excellent team behind him.
Ring in the new

It is now some 20 years since the problems of paediatric cardiac surgery in Bristol were highlighted. These paved the road to revalidation, finally approved by the Secretary of State for Health, Jeremy Hunt, at the latter end of 2012, and what a long and winding road it has been.

The finished product may not mirror the original intentions; however, it is certainly more pragmatic and thus potentially of greater value to us all than that originally outlined. The naysayers may harp on about how it is just a tick box exercise but they often fail to recognise the positive benefits of reflective practice in all its aspects; particularly related to case mix, adverse outcomes and value of CPD activities and how far along that pathway we have progressed over the years since the idea of revalidation was first aired. It has already started to change the ways in which we practise and work. It is fitting that this is reflected in this new year edition of the Bulletin.

Blue skies, horizon scanning and landscapes

One of the ‘joys’ of being President is the opportunity to attend a plethora of high level meetings – with a largely similar guest list – tasked by a variety of august senior figures in medical politics to find or suggest solutions to a series of questions which are causing anxiety at a political level.

Two recurring topics are that of medical leadership and workforce. Concerns abound at the lack of engagement of clinicians in the medical leadership agenda and in particular with the wholesale changes being introduced in England to the delivery of healthcare and education under the auspices of the Health and Social Care Act. The problem is not new: an article in the BMJ some ten years ago highlighted some of the reasons as to why doctors were disenchanted and unhappy.

The concerns regarding the lack of engagement in the leadership agenda resonate through the highest levels of the DH and the Medical Director of the NHS, Sir Bruce Keogh, has been tasked with providing an analysis of the problems and suggesting possible solutions. Following a series of facilitated workshops held across England a consensus view was distilled down to a simple cartoon – my thanks to DR Associates for permission to reproduce it. It does, however, enunciate the key issues and very accurately defines the possible solutions but not the means by which they might become a reality. The abiding message is that you have to give clinicians ownership of a problem and its solution to ensure engagement and that top down dictates are all too frequently met with cynicism and disengagement – the inference being that as clinicians we often perceive ourselves to be natural leaders and are reluctant to be led. The much paraded mantra of local solutions for local problems still seems a distant dream to many.

This theme was echoed at the autumn CfWI annual conference where the construct of the healthcare workforce and its future development was debated in a multidisciplinary forum. Pressures abound to increase the contribution of non-medically qualified staff to deliver care, likely to be accelerated by the developing Local Education and Training Boards. There will be no solutions that please all of the people all of the time and I am conscious of the concerns of trainees over their future careers and the prospect of a very different consultant career pathway to that of the present generation. Equal concern is expressed by our SAS and career grade doctors and fears for the lost tribe of post CCT fellowship doctors abound. The College is actively engaged in the debate upon the future shape of training and of the workforce and continues to be proactive in the collection of independent accurate data to inform the discussions.

The imminent publication of the ‘Francis Report’ has resulted in an array of publications from a variety of organisations including the GMC, NHS Confederation and others seeking to support those who raise concerns. There is a real need to develop a cultural environment where concerns can be raised and appropriately acted upon.

Dr J-P van Besouw

President

The President’s Statement
without redress to the individual who initiates that concern. There have been far too many reports over the years of organisations seeking to protect their own reputations at the expense of the individual be it staff or patients. Sadly, this is something not confined to medical care as recent high profile stories from other walks of life have shown.

**Alphabet soup**

Whilst the future of the clinical excellence awards process remains firmly under wraps at Richmond House, there is much debate as to how anaesthesia and the College should progress any 2013 round of national awards. Our current process is reliant upon regional submission, sifting and ranking followed by a further central sifting and ranking process. It is becoming increasingly difficult to administer this process as the number of senior award holders in each region is ever decreasing due to retirement and the continued lack of success of our specialty in comparison to others in gaining national recognition for our achievements through the ACCEA process. Further disincentives abound and only the most tenacious overcome the many hurdles to national submission let alone success. Many colleges now administer the nominations process centrally and I have asked our own ACCEA group to consider how we might conduct the process in whatever guise it might continue.

**This is your life**

Despite the approach of our silver jubilee as a free standing college we have been remiss in many ways in recording our history with a rightly proper concentration on the here and now rather than the past as we grew and developed. Many other colleges record their history through the remembered lives of their Fellows and Members, e.g. The Royal College of Physicians’ Munk’s Roll. This serves as a useful repository of information for historians and archivists. The College has previously considered such an endeavour but for a variety of reasons this has failed to materialise. Our recently appointed archivist Professor Tony Wildsmith, together with his College Archive Group, is keen to revisit the project and will be taking this forward in 2013 along with a number of other initiatives to record and capture our history.

**Lights, camera, action...**

One of the perennial questions asked of me and of Council members is why do we not read, hear, or see anaesthetists or anaesthetic related pieces in the print, radio or television media despite us being the single largest hospital specialty. To that end we have engaged in dialogue with press, radio and television journalists to ascertain their perceptions of our specialty and how we might increase our media profile. Our congratulations, however, must go to Consultant Anaesthetist, Dr Danny Bryden of Sheffield, who has done more to enhance our status as a specialty with the UK public through her sterling efforts in reaching the final stages of the Great British Bake Off: more than any kudos that we might garner from an interview on the Today programme?

**Reference**


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**STOP PRESS**

**ACCEA 2013 round**

The Chair and Medical Director of ACCEA have set out a possible timetable for a round of Clinical Excellence Awards in 2013. The timetable is based on certain assumptions, details of which are available on our website at www.rcoa.ac.uk/node/3000.
Dr (now Professor) Stephen Bolsin was an anaesthetist working in the paediatric cardiac unit in Bristol. He had noticed that babies and children having open-heart surgery appeared to have a higher mortality and poorer outcomes, compared to other units in the country. He began to collect data on mortality, which he presented to members of his department, and to other colleagues both locally and at the Royal Colleges and the Department of Health. At this time it was considered highly unusual to undertake audits across specialties, and he did not always enjoy the full support of his colleagues in carrying out his work.

By 1992 data had been amassed on over 200 children who had undergone open-heart surgery. The results were both clear and disturbing. Around one-third of all the children who underwent open-heart surgery had received less than adequate care. More children died than might have been expected – in the period from 1991 to 1995 between 30 and 35 more children under one died after open-heart surgery in the Bristol Unit than might have been expected had the unit been typical of other units in England.

The public was left to wonder how the medical establishment could have allowed this to happen, and why they had permitted this to go on for as long as it did. A national inquiry (‘The Kennedy Inquiry’) was set up and made more than 200 recommendations. Many of these revolved around regulation of the quality and safety of healthcare. Key issues that they identified included the setting up of critical incident reporting, outcome measures and audits, patient feedback and the monitoring of standards. Many of these are now embedded into routine practice.

The report also called for the introduction of a new system for revalidation, whereby healthcare professionals would be periodically required to demonstrate that they remained fit to practise. Developing the processes to put this into place has been complex, and it has taken place in stages. But this year we have seen the formal introduction of revalidation.

The work carried out by Professor Bolsin, his persistence, vision and attention to detail, were instrumental. So it is very appropriate that later this year he will be delivering the Frederic Hewitt lecture – one of the most prestigious lectureships that the College can award – and will be awarded a College Medal in recognition of his pioneering work. Professor Bolsin now works in Australia, where he has been responsible for many significant developments in clinical audit and patient safety, and his lecture is sure to be both informative and thought provoking.

Local clinical governance meetings

One of the most important mechanisms for ensuring patient safety is the local clinical governance meeting. These meetings serve two functions. They act as a focus for looking at clinical practice within a hospital, and are a forum to review areas where individuals or departments could improve their performance. But they also act as the place where decisions on clinical matters can be made, and agreement reached across the department. So the meetings are the effector organs for departmental policy.

The College is aware that some departments find it increasingly hard to run these meetings and to maintain a reasonable level of attendance. Whilst appreciative of the difficulties involved, I do believe that if we
are to espouse the values of clinical governance then these meetings should be given a high priority by both individuals and their departments.

Patient feedback
The difficulties of gaining meaningful patient feedback in a specialty such as anaesthesia are well known. Our patients are often asleep, unaware of the complexities of our task, and possibly unable to judge some of our practical skills. But that is only a part of our job. We have short, stylised and intense conversations with them, during which we need to both receive and impart a good deal of information. For many patients their brief conversation with their anaesthetist is a significant milestone in their hospital stay, and one that can make a lasting impression.

It has been asserted that patient feedback can do no more than pick out the discourteous, unhelpful and uncommunicative doctors. Yet surely this is an important subgroup of doctors to identify. We pride ourselves on being qualified doctors, not merely technicians, and our patient skills and bedside manner should reflect this.

Dr Moonesinghe and colleagues have worked with the Patient Liaison Group to look at ways of implementing patient feedback – her report is on pages 28 and 29.

Remediation and mentoring
Another important aspect of revalidation is dealing with doctors who are performing below par. Dealing with remediation is a difficult and sensitive area. Anna-Marie Rollin has represented this College on the Academy of Medical Royal Colleges Working Group on Remediation, and she has written a summary of their guiding principles on pages 26 and 27. Whenever possible, remediation should be managed at a local level, with close liaison between the doctor and his or her colleagues.

The Academy report has also highlighted the issue of mentoring. This is something that I believe has many benefits. Those entering the early stages of consultant life could be paired with a more senior colleague – and we should remind ourselves that ‘paternalism’ was once considered a positive and endearing attribute. Similarly, those at the later stages of their careers might appreciate a close but formal relationship with a more junior colleague within their department, who can ensure that they remain abreast of recent developments.

Just a tick box exercise
The cynics have argued that revalidation is simply a box-ticking exercise designed solely to placate politicians and the press. I wish that this were true. Because although the majority of doctors practise medicine to a very high standard, and should tick all the boxes without any difficulties, there remain a small number who give cause for concern. Revalidation will provide the tools and infrastructure to identify this tiny minority.

Doctors have always had a moral obligation to protect patients from bad doctors. But despite this ethical justification it is a rare occurrence. Why is this? Some of us are inclined to be charitable to colleagues – we all have difficult cases and we should give the benefit of the doubt. Some plead ignorance, or worry that becoming a whistleblower could harm their own career. Others claim that the outcome to the patient will not change; therefore, why go through all of those unpleasant steps for nothing? But this simply is not true. Following the work of Professor Bolsin‘ the mortality rates from children’s heart surgery in Bristol fell from 30% to less than 5% – one of the most important clinical improvements brought about in the NHS.

If revalidation works in the way it was intended then poorly performing doctors would be identified, and steps taken to address their problems promptly and expeditiously, before patients could come to harm. And that would indeed be a very satisfying box to tick.

I am very grateful to the work done by Liam Brennan, my predecessor as Revalidation and CPD Lead, and to all the staff in the Professional Standards Directorate who have been working extremely hard to develop processes for supporting our specialty.

References
It has been a tremendous privilege to serve as an elected SAS member of Council; however, after eight years my term of office ends in March this year. My final article is a brief reflection on our progress over this time.

The two elected SAS Council members together with our SAS committee, now renamed career grade committee (CGC), have worked hard to enhance respect and recognition for our grade. The focus has been to engender an inclusive approach such that equal opportunities for teaching, training and career progression are available to all – consultant, SAS and trainee grades alike. Two new faculties have been developed within the RCoA – pain medicine and intensive care; and we have ensured that these too are respectful of our interests.

Regional representation
I have been ably supported by our four regional representatives on the CGC and I would urge you to contact and make use of their expertise for any issues or items of interest you may have – email addresses are available on our website. We recognise that communication at local level is also important and over the past couple of years we have been pleased to provide representation at local regional meetings.

Resources
We have developed a number of resources, all available on our website; most significantly these include:

2. Equivalence assessment guidance for GMP 1a (2010).

We have recommended that all departments employing SAS/SD anaesthetists identify a named educational supervisor responsible for overseeing their career development. Furthermore, the educational supervisor should link with the College Tutor, who is able to provide additional guidance and support. This can include a recommendation for you to be included in the training e-portfolio as an assessor.

There remains access to the fellowship examination for SAS doctors and for those of you who have become Fellows please do consider applying to become an examiner for the College – this too is now open to interested Fellows of all grades who meet the criteria.

Future challenges
The workforce and nature of training are likely to continue to undergo developments with the changing medical demographics and reduction of trainee numbers. Through the shape of training review we have emphasised the desire for greater flexibility in training structures. Please do go online and contribute.

Quality assurance of training is being enhanced through the GMC’s consultation on the recognition and approval of trainers. There is clear support for the SAS grade and an implementation plan was published in August 2012. This will require all named educational supervisors and named clinical supervisors to meet standards which have been set out by the Academy of Medical Educators and comprises seven domains. The intention is for the GMC to develop a legal structure which will formally recognise these two trainer roles (as well as two specific roles for undergraduate education) to be completed by July 2016. Most SAS doctors are likely to be using their skills as sessional supervisors, and the local responsibility for this will be devolved to College Tutors to ensure trainers and assessors meet the criteria published in the CCT curriculum.
The GMC’s consultation on routes to the specialist register closed in June 2012 and is likely to significantly change the equivalent mechanisms by which SAS doctors are able to become included on the specialist register. If adopted the emphasis will move to a predominantly prospective process requiring the use of workplace based assessments to evaluate clinical practice. One of the aims is to reduce the perception of a CESR (or CESR(CP)) as being less desirable than a CCT. There is the potential for the new routes to accommodate greater flexibility for training and career progression although the increased demand and access to educational supervisors are a concern. As ever, possession of a CESR is only one of the qualities and requirements that you will need to successfully apply for a consultant post.

Soon the revalidation process will start in earnest. Please do assimilate the wealth of information available. We believe that many in the SAS grade still do not have regular enhanced appraisals based on the GMC’s four domains of good practice and it will be essential for all of us to engage actively in this process. The Academy of Medical Royal Colleges has produced guidance which recommends that 1.5 SPAs will be needed to support revalidation and yet it is sadly still the case that most SAS doctors only receive one SPA in their job plans.

**Thank you**

Lastly, I would like to thank all the members of Council, College staff, colleagues and my family who have supported Andy Lim and myself on our journey over the past 10 years.

**Further reading**

- Shape of Training Review 2012 (www.shapeoftraining.co.uk).
- Recognition and Approval of Trainers. RCoA, 2012 (www.rcoa.ac.uk/node/269).
Educators in acute care: those that can...teach

As part of a novel pilot project designed and sponsored by the East Midlands Healthcare Workforce Deanery, Acute Care Common Stem doctors Jenny Briggs, Ricky Bell, Emmanuel Davidson and Christopher Hebbes were appointed to an Education Fellow training programme with a 3:2 split between Acute Care Common Stem (ACCS) rotations and academic time. Academic commitments enabled them to complete an MMedSci in Medical Education. They reflect on the advantages and disadvantages of combined training.

Combining clinical and non-clinical training – why bother?
The European Working Time Directive (EWTD) and shortened working hours all put pressure on training programmes, curriculum and clinical time, particularly during the formative novice period in anaesthesia. In the light of this, why consider taking on the additional burden of another degree, teaching, research and academic commitments and a prolonged training programme?

A not unreasonable concern, where, by their own admission, the RCoA places emphasis on an uninterrupted period of training during the three-month novice period, discouraging less than full-time (LTFT) training in order to allow candidates to complete their Initial Assessment of Competence in Anaesthesia (IAC).

Despite these concerns, crossing the novice period and introductory years in anaesthesia with another interest can carry both clinical and non-clinical benefits. Trainees gain additional experience, the departments in which they practise benefit from the flexibility of part-time workers and patients benefit from trainees’ additional skills. These early milestones, whilst important, are not necessarily compromised by this training scheme. The value of academic medicine and LTFT training is recognised by the GMC and LTFT is recognised and provisioned for in other specialties, although uptake is variable across the country.

Benefits to departments and organisations
The East Midlands Programme utilised a four-way, collaborative relationship between the East Midlands Healthcare Workforce Deanery, Universities of Leicester and Nottingham and the East Midlands School of Anaesthesia (South), a unique integration of administrative, academic and clinical organisations.

Clinical organisations benefit from part-time trainees. They stay in one place for longer in order to achieve the same whole-time equivalent, which enables cover over difficult changeover periods albeit with the complexities of organising a part-time rota. This longevity also allows for better working relationships with the clinical team.

The deanery and universities benefit from clinical input to the design and implementation of teaching programmes and to research-related activities. Throughout the East Midlands programme, the education fellows gave clinical perspectives to the implementation of a deanery-wide Virtual Learning Environment, which grew from a deanery-led pilot project. The university benefited from the implementation and continuation of basic sciences teaching in cardiac and respiratory physiology (see photo). A pool of trained educationalists within the clinical and academic environment provided a resource available to colleagues of different levels.

Mentoring and wellbeing are another strand to the East Midlands programme; all of the fellows are trained mentors through the East Midlands Mentoring programme, which uses Egan’s Skilled Helper model. These additional skills enable the educational fellows to undertake different roles, in self- and peer-mentoring, and as personal tutors. Mentoring skills also provide mutual benefit to patient communications and team working.
Benefits to trainees

The experience of managing academic and clinical commitments, and the rigor of completing study for a higher degree, place additional demands on trainees. However, these demands of balancing busy clinical commitments, supporting activities, study, audit and research and the need to demonstrate clinical competence are exactly those faced by consultants. Change in role from core trainee to registrar, and then consultant, places stresses on individuals. Developing the skills to manage change and complexity is therefore a valuable addition to medical training which is traditionally lacking.5,6

Collectively, the education fellows developed individual diverse areas of interest and expertise in teaching, simulation, self-regulated learning, e-learning, assessment and professionalism and have had the opportunity to present in the UK and abroad.

There is significant support from doctors’ regulatory bodies for teaching activities. Medical education, the maintenance of standards and training the next generation of anaesthetists are a key mission of the Royal College of Anaesthetists.7 The General Medical Council also places significant importance on doctors developing ‘the skills and practices of a competent teacher’.8 The roles of the clinical educator cross over into clinical practice and include teaching, assessment, facilitating, planning, personal development and acting as a role model.9

Benefits to patients

Health-related behavioural change through patient coaching and teaching is a new area which carries benefits to the longer-term health of patients for which mentoring and teaching skills, such as those gained through this programme, will be invaluable in the future.

The ability to pursue other interests has enabled the education fellows to focus on personal and team development using tools such as the Myers-Briggs personality type indicator. This enhances patient safety through building attributes such as team working, leadership and situational awareness.

Problems and issues

The programme was not without challenge to trainees; the initial few weeks were relatively unstructured, giving freedom and flexibility to plan and scope out the coming programme of work. However, this perhaps encouraged trainees to over-commit to projects and teaching, a salutary lesson learnt about understanding that time itself is a resource. Managing the time of four people with very different expectations and clinical commitments can also be challenging and create tensions between clinical and educational responsibilities.

Educational trainees were subject to the same examination rules as non-academic colleagues, and completing specialty examinations whilst having other commitments with the deanery and the medical school was a challenge. Undertaking study for a master’s degree and the Primary FRCA took careful planning.

Pay is another consideration for this type of post; whilst the East Midlands pilot was pay protected, a conventional LTFT post would be either pay reduced, or funded from other sources.

Training medical academics into the future

This venture broke new ground as an innovative and experimental project that broadened access to academic careers. Trainees found it enjoyable and stressful in equal measure and gained skills to serve them as registrars and beyond. They formed clinical and non-clinical working relationships which will last into the future. The challenges were significant and, in particular, the stresses and demands of the course caused exam difficulties for some, which were, however, overcome. This undertaking wasn’t for the faint hearted and required significant time investment and support, which was fundamental to the success of the programme. As medical educationalists, the trainees can hold their own with an evidence-based riposte to those who trumpet the ‘good
old days’ of negative marking and the classical viva, and can give constructive feedback to colleagues in addition to providing useful suggestions for their training. Students and now trainees are no longer the passive receivers of education but are consumers. The introduction of higher fees places an expectation of high quality training; locations without high quality training will lose their trainee allocations. This obligates trainers wishing to be a part of medical education to ensure that they are appropriately experienced and qualified to provide that training.

In a challenging world, we need more innovative programmes to ready our trainees for a future in which survival requires a portfolio of interests. Such curricula would allow trainees to develop additional interests and the skills to manage a busy schedule which would serve them well in the future (Figure 1). Trainees are all different, and these programmes allow them to flourish without being constrained by a restrictive curriculum, designed with a focus on traditional educational thinking rather than the future needs of the profession, patients and service.

During this programme, trainees met and exceeded training requirements, but have also shown the value of a parallel stream focusing on other skills in addition to the technical aspects of anaesthesia. Perhaps this could serve as a new model of training, developing trainees more resilient to cope with their future professional demands.

**Take home message**

Whilst achieving clinical competence is paramount, it should not be to the detriment of other areas. Trainees should actively be encouraged to develop other parallel interests, and LTFT should actively be encouraged. However, doing so requires significant motivation and support from hospitals and key figures in order to ensure the financial, pastoral and clinical support necessary. We were fortunate to receive such support from the Deputy Postgraduate Dean, the School of Anaesthesia (East Midlands South), and our consultants and colleagues, to whom we are indebted.

**References**

2. RCoA position statement – LTFT. RCoA (www.rcoa.ac.uk/node/1535).
7. Key points on the provision of anaesthesia services. RCoA, 2009 (www.rcoa.ac.uk/node/895).
Help there’s a flexi on my rota

How to successfully include less than full-time trainees into your rota

The co-ordinating of trainee shift rotas is essential for the smooth running of any anaesthetic department but it can be a tricky and often thankless task.

The addition of a ‘flexible’ or less than full-time (LTFT) trainee into the rota planning can be enough to bring even the most experienced rota master out in a cold sweat.

Once you get to grips with a few simple concepts, however, incorporating an LTFT trainee into your rota really isn’t as difficult as it may first appear. It should also be viewed as a useful skill for the future as this is a way of working that is getting more and more popular every year.

Some useful tips to get you started

Having done this many times myself, my first and most important piece of advice is to ensure good communication between yourself and the trainee in question. Get in contact early and engage them in the process. You will probably find this can make your job significantly easier and things can quickly go wrong if this simple step is not followed!

An understanding of the ‘rules’ of LTFT training is also useful to know. It can be very alien to think of trainees specifying when they can and cannot work if you have only ever worked full time in the past. Remember, though, there is usually a good reason why people specify certain days or times that they can work, e.g. fixed childcare. What is traditionally termed a day ‘off’ is often far from the reality!

The following is a description of some of the basics of LTFT training and a few tips on how to use this information to successfully write a rota. Some of the finer points may vary a little from region to region but you won’t go far wrong if you keep to the basics.

Basic rules of LTFT training

There are several types of working arrangement:

Slot share
Two people are sharing the same trainee slot on the rota. The two people work autonomously however, have separate contracts and may overlap sessions. The trainees may wish to share the work contained in the full-time post, or it may be more appropriate for the trainees or department for them to work independently. It usually works best if all days of the week are covered by the two slot share partners but this is not an obligation.

Reduced sessions in a full-time post
A single LTFT trainee is allocated to a full-time slot. In this situation there will be uncovered daytime and on-call sessions. These sessions should be covered on a locum basis or other locally agreed arrangement.

Job share
Two trainees divide one full-time person’s job equally between themselves. This is very rarely done and is very difficult to co-ordinate.

Supernumerary
Supernumerary posts are those posts which are in addition to the usual complement of training posts in your employing trust. This is rarely done, however, and requires individual educational approval.
Trainees’ Topics in Anaesthesia

Working arrangements

Working arrangements (i.e. slot share or reduced sessions) often change from job to job within a rotation and are usually decided upon by the programme directors based on the needs of the LTFT trainee and others on the rotation. This means in a slot share arrangement, for example, the LTFT trainee may well not have worked with their slot share partner before.

The trainee can work between 50 and 90% of full time; this is calculated on a pro rata basis (i.e. 70% of full time equals approximately 70% of the hours of full-time colleagues) or sometimes on sessional basis (i.e. 7 out of 10 sessions). The percentage of on-call commitments will vary, however, depending on the job plan and local arrangements. Usually in a reduced sessions post it will be pro rata but in a slot share arrangement it may well be 50%. The number of hours worked per week and the percentage of on calls will be reflected in the pay banding of the individual trainee as calculated by the medical staffing department of the hospital based on BMA guidelines.³

The trainee should usually be allowed to choose the days of the week they are able to work, the number of regular days depending obviously on the chosen percentage of full time. On-call commitments can usually only be expected on the days that the trainee would normally work. With regard to weekends there are only very few circumstances in which a trainee would not be able to work weekends, so you should assume unless they tell you otherwise that they will do the same proportion of weekends as week on calls. A reciprocal degree of flexibility is sometimes needed to make these arrangements work optimally!

Annual/study leave is again calculated pro rata based on the trainee’s original full-time entitlement.

Writing the rota

Now you are equipped with the basic information you should be ready to move on to organising the rota.

The first and most important step is to get in touch with the trainee or trainees.

The information you need to know from them is:

- What percentage of full time they work
- What days of the week they work
- What days of the week they are available to do on calls
- What the working arrangement will be.

You should hopefully be in possession of a template for the full-time rota.

A very useful thing to do for all involved is to send out this template to the LTFT trainee and ask them to indicate which shifts they would be able to do. This achieves several things in one step. Firstly, the trainee/trainees can see the working pattern and if slot sharing can start organising themselves; secondly, you have an idea how things will work; and finally, the LTFT template can be sent to medical staffing for banding calculations. In some hospitals you may find that this step is co-ordinated by the medical staffing department; I have not found this to be the case in most places, but it might be worth asking!

The next steps will depend mainly on the working arrangement. Only slot sharing and reduced sessions arrangements are described below as these are the most frequently encountered situations.

Slot sharing arrangement

The most important thing to know is which days of the week the trainees work.

The best and most frequent arrangement in this situation is that between the two trainees all the days of the week are covered. This would usually mean also that they will cover all the on calls that the full timer in that slot would have done (i.e. work 50% of the on-call rota). In that case your job is fairly easy: just allocate the on calls as you would normally and the slot share partners will sort it out themselves.

Things can start to get a bit more tricky if the two slot share partners are not able to cover all the days in the week, e.g. neither works on a Thursday. In this case the LTFT trainees would just need to do proportionally more on calls on Monday, Tuesday and Wednesday. Depending on the size of the department and the design of the rota this may or may not cause an issue in the writing of your rota. If it is a big issue some negotiation may be needed! Speak to the slot sharers and see how flexible they are; it may be, as long as they know in good time that they can make arrangements to cover (remember though, that it is not an obligation for them to cover all the days of the week). Alternatively, discuss it with the consultant in charge of your rota; there may well be other solutions.

With regard to weekends you should expect that all the weekends will be covered in this situation. Some will prefer to do full weekends less often and others will prefer to split weekends. Whether or not split weekends are considered acceptable will probably vary from rota to rota so check with the consultant in charge.

Reduced sessions in a full-time post

Usually the trainee in this situation will do the same proportion of on calls as
their percentage of full time, i.e. if they do 70% of full time they will do 70% of
week day on calls and 70% of weekends.

If you have managed to get an LTFT
template for the trainee (as described
above), then organising a reduced
sessions rota should be relatively easy
as the slots that need to be covered
should be easy to identify.

Whether leave is incorporated before
or after this step will depend on how
the rota is usually composed.

Once the rota is done it is generally
best to check that the hours
and percentage of on calls is
approximately correct. The trainee
themselves is probably the best
person to tell you this. Alternatively,
run it past your consultant or medical
staffing department.

Covering gaps
How to cover the shifts that the LTFT
trainee or trainees cannot do is the
final question and will vary between
departments. This will usually be
more of an issue with a reduced
sessions arrangement.

Options are:
1 Internal voluntary locum cover
2 External locum cover
3 A rota written (and appropriately
banded) specifically to incorporate
the LTFT slot.

Options one and two are most common
as rewriting and rebanding a whole rota
can be very time consuming and need
to be done well in advance.

What should not happen is that the
other full timers on the rota end up
doing extra uncompensated hours
because of the LTFT trainee. This would
be very unpopular for obvious reasons.

So, good luck for your rota writing!
Remember, it’s just a few simple rules
and then it’s all about communication,
communication, communication.

References and useful links
1 Gibb S, Carey S. Less than Full Time
Training in Anaesthesia – an A to Z Guide.
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default/files/GAT%20LTFT%20Guide.pdf)
(accessed 20/8/12).
2 Less than full time training. AAGBI, London
(www.aagbi.org/professionals/trainees/
training-issues/ltft-training) (accessed
20/8/12).
3 A guide to flexible training. BMA, London
(http://bma.org.uk/developing-your-career/
foundation-training/flexible-training).
On the other side of the drapes
Those of us who have spent many hours on labour ward will be able to recount our experiences of category 1 caesarean sections (CS) and massive blood loss. The potential morbidity to mother and baby makes this a stressful situation for all. As a result it forms an important teaching topic, simulation scenario, and is a favourite FRCA exam topic. However, no matter how much literature we read, we are continually told how there is no substitute for experience. But what if that experience is on the other side of the drapes?

Last year I gave birth to my son in less than ideal circumstances. Having had a straightforward labour previously, I was expecting much the same, but unfortunately things were drastically different. I suffered a placental abruption, massive blood loss and an overnight stay on intensive care. Although a terrifying experience at the time, it has retrospectively led me to consider my management of such cases from a novel viewpoint and explore the current literature.

Something to MEWS over
Modified early warning scores (MEWS) are now widespread in the non-obstetric population and following the 2003–2005 triennial Confidential Enquiry into Maternal and Child Health these have been adapted for the obstetric population: modified early obstetric warning system (MEOWS). Many hospitals now have their own MEOWS observation charts to aid early recognition of the acutely unwell parturient with certain trigger thresholds requiring mandatory review by a clinician. A recent study attempted to validate such a scoring system and found the MEOWS was 89% sensitive and 79% specific, concluding that MEOWS is a useful bedside tool for predicting morbidity. Such scoring systems are therefore clearly valuable, but are midwives now focusing too much on physiological parameters rather than using their history taking and examination skills?

My physiological parameters did not trigger a clinical review until I had undergone rapid sequence induction. In the preceding few hours I had experienced a profound feeling of thirst and a sense that not all was well. On expressing my concerns my blood pressure and pulse were checked, CTG was good and so I was reassured and brought a jug of water as everything ‘on paper’ was normal. As my thirst worsened and my once bulging veins disappeared I persisted to annoy my midwife until she reluctantly called for an obstetric review. As the obstetric registrar walked into the room my waters broke revealing my concealed haemorrhage and the usual panic ensued.

Unfortunately, I was one of those ‘false negatives’ that the MEOWS failed to pick up. My midwife did nothing wrong, but I fear there may have become an over-reliance on scoring systems. They are not foolproof and will never have 100% sensitivity and specificity. The majority of parturients are young fit individuals who compensate well with regard to physiological parameters. However, symptoms of thirst, feeling cold and signs of peripheral shutdown may be present several hours in advance, so are these the true early warning signs in this specific population? A thorough history and examination can reveal so much and we must not forget this as an increasingly protocol heavy NHS develops.
On the receiving end

Induction of general anaesthesia for emergency CS has historically consisted of a rapid sequence induction with thiopentone and suxamethonium and is still the method of choice in the UK. While this may be the most appropriate form of induction for category 1 sections resulting from severe pre-eclampsia, one may question whether ketamine may be preferential in cases of massive haemorrhage where fetal distress may prevent adequate time for pre-operative resuscitation. There is certainly appropriate theoretical justification for its use and it has been widely adopted in the developing world and in military anaesthesia.3

My overall blood loss was estimated at 3.5 litres and I was probably already two litres down when I got to theatre. With no time for preoperative resuscitation I feel the use of ketamine could have been justified in my case. Would this have reduced the use of vasopressors and potentially a more stable induction? Would I have had better analgesia? Or, would I have been plagued by nightmares? I will never know, but it gave me food for thought.

In placental abruption blood loss is rapid with gravid uterine blood flow estimated between 600-900ml/min at term making adequate resuscitation pre-operatively unlikely. By inducing anaesthesia with ketamine, cardiovascular stability may be better preserved avoiding the classic crash in blood pressure seen with thiopentone. Krissel et al randomly allocated 75 parturients undergoing elective CS to receive thiopentone, thiopentone/ketamine or ketamine for induction of general anaesthesia. Thiopentone resulted in the most pronounced and ketamine the smallest drop in blood pressure, while the combination induced only moderate haemodynamic changes.4

In addition to ketamine’s vasoconstrictor effects there are suggestions that its amnesic properties may reduce the incidence of awareness. Baraka et al looked at maternal awareness after ketamine induction of anaesthesia for elective CS. Intra-operative awareness was assessed by the isolated forearm technique. In all patients (n=20) the isolated arm test was negative, i.e. there were no incidences of maternal awareness.5 A second study compared ketamine to thiopentone in a case series of 50 patients. In this study, awareness was found to be significantly greater after induction with thiopentone than ketamine, and there were no differences in Apgar scores or umbilical vein blood gas values in the newborn.6

Ketamine is also a well established analgesic. These properties may be beneficial prior to delivery when opiates are precluded and may last into the postoperative period. Ngan Kee et al compared the postoperative analgesic requirements after CS following induction with thiopentone or ketamine. Median time to first morphine PCA demand was greater in the ketamine group and median morphine consumption was 10 mg less over the first 24 hours. The authors concluded that induction with ketamine is associated with lower post-operative analgesic requirements compared to induction with thiopentone for CS under general anaesthesia.7

Despite these possible benefits, ketamine is well known for its distressing side effects such as delirium and hallucinations. In the 1970s Meer et al looked at 68 parturients undergoing general anaesthesia with ketamine for CS. In this study the incidence of postoperative delirium was 3%. They concluded that ketamine was well tolerated by both mother and infant.8 In Ngan Kee’s study above they looked at delirium and unpleasant dreams as a secondary outcome and no patients reported either symptoms. However, in Krissel’s study six of the patients receiving ketamine at induction reported nightmares.4

Grin and bear it

Postoperative pain after emergency category 1 CS has routinely been managed with oral paracetamol and diclofenac combined with a morphine PCA in the institutions at which I have worked. Until now I have never given this much thought as it seems entirely reasonable, and during follow-ups it never seems to have been excessively used.

However, I now question whether mothers are not using their PCA much because of minimal pain, but rather because it makes you feel so awful that it interferes with bonding and breastfeeding your new baby. For me it was the latter. After 15 mg of morphine intraoperatively and a few presses of my PCA several hours later, I could hardly lift my head off the pillow. I decided instead I’d rather ‘grin and bear it’ as I still hadn’t managed to see my son’s face in focus.

This experience has led me to consider the use of trans-abdominis plane (TAP) blocks for parturients who have not had the benefit of spinal diamorphine and the evidence seems to be positive. A randomised control trial using ropivacaine versus placebo (saline) for TAP blocks after caesarean delivery showed that the ropivacaine group had reduced visual analogue scale (VAS) pain scores and reduced morphine requirements in the first 48 hours postoperatively.9
A 2009 Cochrane review looking at local anaesthetic wound infiltration and TAP blocks during CS also concluded that ‘women who had a general anaesthetic and the abdominal wall nerves blocked had reduced pain scores within the first 24 hours post-operatively’. These conclusions were based on 20 randomised control trials involving 1150 women.10

Childbirth is a profound emotional experience. Any form of intervention that leads to improvement in pain relief positively impacts on this. By considering the use of TAP blocks as part of a multi-modal analgesic regimen we can reduce morphine requirements and its undesirable side effects.

So, what have I learnt?
Well, as any medic knows, it’s not easy being a patient and I feel very lucky that both myself and my son are fit and well. Good team work really does save lives and I will be eternally grateful to those involved in my care.

Maternal obstetric haemorrhage is now ranked the sixth most common cause of direct death in the most recent Confidential Enquiry into Maternal Deaths; however, it is still the most common cause of obstetric intensive care admissions and a recurring reason for this is poor recognition of bleeding and failure to act on signs and symptoms.11

So, would I now alter my management based on what I have learnt? Well, my experience of ketamine for induction of anaesthesia is pretty sparse. I’ve used it only twice in adults and twice in very sick infants and only in the presence of a supervising consultant. So, I think I’d like some experience of it on labour ward or at least get the consensus of my department before I used it during the middle of the night. TAP blocks, definitely. There is good evidence to support their use and I feel happy to do them without supervision. My faith in MEOWS scores has been shattered, so I will always start from the beginning if I’m asked to review a parturient.

Reflection is a positive learning experience which has led me to research the literature around the questions I have asked myself and as a result I have changed my practice. I sincerely hope no one ends up reflecting from the same viewpoint as I did, but I hope my experience has given others food for thought. So, what’s next? Well, I’ve been the patient; I’ve been the anaesthetist; now I just need to view things from the surgeon’s perspective. Scalpel anyone?

References
The HSRC has established a working group to develop a ‘quality framework’ for measuring and reporting clinical outcomes relevant to anaesthesia and perioperative medicine. The group encompasses clinicians and academics, and is tasked with this work in order to address the need to report our clinical outcomes as part of our portfolio of supporting information for revalidation, as well as (more importantly) to enable quality improvement and, finally, in order to facilitate health services research.

Quality of care may be measured using Donabedian’s model of ‘structure’ (the environment in which healthcare is delivered), ‘process’ (the method of healthcare delivery), and ‘outcome’ (either patient reported or objective, such as mortality). Structural elements might include measures of theatre efficiency, departmental characteristics (e.g. number of consultants, trainees and specialty doctors) and availability of particular technologies (e.g. ultrasound machines). Process measures are more familiar to those of us who engage in departmental audits, and often focus on adherence to ‘best practice’ guidelines – for example, compliance with the WHO checklist, adherence to protocols for venous thromboembolism or perioperative antibiotic prophylaxis, or rates of use of the oesophageal Doppler in major open abdominal surgery. Outcome measures may be divided into patient reported (e.g. satisfaction, quality of recovery or pain scores) and objective (e.g. mortality or complications).

In order to develop a framework for assessing quality of care in anaesthesia, we are initially looking to define what is already being measured ‘at the coal face’, in order to determine feasibility of recording and reporting some of these metrics in a systematic manner across healthcare institutions. The Quality, Audit and Research Coordinators (QuARCs) in each anaesthetic department (or the Clinical Directors in departments who have not yet nominated a QuARC) will have recently received an email from the College asking them to complete a short online survey asking for information on which measures are currently collected in their department, the frequency of data collection, and the methods (if any) of the feedback of these data to practising anaesthetists.

What will this information-gathering exercise help us to achieve? Ultimately, we should be aiming for nationally co-ordinated data collection (in order to enable meaningful comparison between institutions), and structure, process and outcome measures. Alongside the rest of the NHS, we should be seeking patient reported outcome to inform our practice. In a resource-constrained environment, we need to define the strategy for achieving these aims without incurring significant extra expense. It is likely that the best system would involve participation in a series of ‘sprint audits’ looking at specific patients or procedures, on a cyclical basis. Infrastructure for a centralised data-entry system, analysis and timely reporting back to trusts will need to be developed. National reports will need to be generated, with areas for improvement highlighted, and centrally co-ordinated re-auditing.

We are a long way from realising this ideal. In order to make a start, your participation in our survey is essential. This will ensure that the development of our quality framework is approached from the ‘bottom up’ rather than the ‘top down’. Implementation of the aspirational system detailed above will take years, and we will need to edge towards it gradually, and in a way which will neither disenfranchise individuals, nor place unreasonable extra financial burden on trusts. However, the key point is that we must get started. Once we have demonstrated ’proof of concept’ – i.e. that systematic nationally co-ordinated data collection in perioperative medicine is feasible, and can benefit patients, clinicians and trusts – then we can only hope that, in the same way that the ICNARC Case Mix Programme has developed, most of us would rather be ‘in the club’ than out.
The Faculty of Pain Medicine is now over five years old. Initial FPM Board members were appointed with a plan to move towards fully elected members as the Faculty became established. Last year, two new members were elected and, as many of you will know, we have recently held our second election. The two successful candidates were John Goddard (Sheffield, paediatric pain) and John Hughes (South Tees, past lead FPM Regional Adviser). We are looking forward to working with the two Johns and are confident that they will make a significant contribution to the developing work of the Faculty.

There were nine candidates and I am sure that each candidate would have made an excellent member of the Board. Of course, it is traditional to say in these circumstances that the voting was close but, believe me, in this case it was very close indeed. We hope that the unsuccessful candidates will consider applying again, as well as others who have yet to consider serving as a Board member.

We announced in September that the electronic FPM logbook was now available as a smart phone HandBase application that can be downloaded from the FPM website. Also, version 2 of the standard electronic logbook is now available. These have been developed by Roger Laishley and Barry Miller; we are very grateful to them for the skill and dedication they have put into this project. Please let us have your feedback on these (good or bad), as they are an important tool in our mission to continuously improve our training and its assessment.

For some time now, we have been concerned about the problems of delivering clinical trials in chronic pain. Some areas of our clinical practice are bedevilled by the lack of good quality evidence arising from large, multicentre studies. On November 1, we held a joint event with the British Pain Society aimed at exploring the development of a UK clinical research network. We were encouraged by the large attendance at this initial meeting. The meeting explored the national clinical research agenda, especially the profound influence of the National Institute for Health Research (NIHR) and specialty specific contributions from the National Institute of Academic Anaesthesia (NIAA). We also heard about the experience of others, including the Scottish Pain Research Community and the very successful NIAA perioperative medicine group. We posed three questions: should a network be constructed; what will it look like; and what are the next steps?

Fortunately, every delegate thought that a network should be formed! Group sessions came up with a consistent view of the potential functions of this network, including regular meetings, accurate scoping of the capacity of member centres to deliver on clinical trials, training events, and enhanced engagement with the NIHR (especially the Anaesthesia, Perioperative Medicine and Pain Specialist Interest Group of the Comprehensive Local Research Networks). The next full meeting of the group will probably be in July of this year but considerable work will be done before this. I hope by the time you are reading this article, we will have pages on the FPM website giving more detail on this exciting development.

Finally, on behalf of the Board of the Faculty, its management and staff, we hope that all our Fellows have had a good Christmas and are suitably refreshed for the many challenges ahead.

Professor D J Rowbotham
Dean
Leadership – a very personal view

Mrs I Dalton
Chairman

We need leaders: to inspire, to make us feel secure and to trust. In a crisis, leaders stay calm because they have the vision to foresee most tricky situations and react coolly and instinctively. They are justifiably self-confident because they know their stuff. Leadership is selfless and for the greater good.

It is not possible to postpone assuming the mantle and deportment of leadership until you are in charge of a significant group of professionals. If you do not exercise leadership from your first days in any profession, you will not be able to pull it out of the hat between the interview and the taking up of a senior post. Arguably, if you are not already showing leadership in a junior post, you should not expect to be promoted anyway.

Leadership is a word easily bandied about. Politicians love it, possibly because it provides a simple means of deciding which general to shoot when things go wrong. It forms part of the curriculum for many professions, but can it be taught? When it appears on the curriculum most of what follows is actually about management and while that is vital because without it nothing gets done, leadership is a far more complex matter. It is not easily broken down into a set of competencies and, essentially, has at its heart a moral purpose. To lead effectively, we have to have principles and to have thought these through. If we feel uncomfortable about some of the circumstances in which we work, it is necessary to consider why this is so and what we are going to do about it. Because we always can.

**Action, not excuses**

It is simply not good enough to accept sloppy or incompetent work because HR, union issues and demarcation disputes will be difficult. Undoubtedly, they may prove both difficult and stressful but if you are acting from principle, not irritation, have done your homework and know the rules, tackling things through the proper chain of command means that you will have fulfilled your leadership role and placed the responsibility for the shortcoming firmly with the chief nursing officer, the clinical director or the cleaning services manager. However, it is a big mistake to assume that because you have passed it on, all is settled. If you report something, then close the trap by setting a date at which you will check back with the appropriate manager. Real leaders are not ignored because they do not go away, nor do they usurp the leadership roles of different hierarchies within an institution; they support them by expecting them to lead, too. If everybody understood this, and acted upon it, ‘whistle-blowing’ (a nasty little term) would not need to be encouraged. But that is another story.

Leadership is teaching by modelling the standards you expect in all that you do. If you expect high standards of dress (and believe me, the average woman in the street talks about ‘proper doctors’ as well as ‘proper teachers’) you can’t appear in trainers. If you expect courtesy from your staff, you can never afford to put people down in public. I did this once, early in headship, because I was exasperated beyond reason by our staffroom barrack-room lawyer, and it took me months to get back my credibility as one who listened.

**Dark nights**

One of the toughest aspects of leadership comes to us in the small hours, when we are facing a difficult and far-reaching decision where, however widely we have consulted, the buck has stopped with us. Perhaps it is worth remembering Immanuel Kant’s ‘Categorical Imperative’, in *The Groundwork of the Metaphysics of Morals*, which amounts to the fact that the only way you know that something is right is when you really, really, don’t want to do it. A lot of leadership is like
that: the difference between being a leader and just a manager or ‘one of the boys’ is you always do what you believe to be right, cost what it may. This is why leaders are dangerous people; they do not accept the status quo; they challenge governments, hierarchies, local authorities, bean counters and even the CEOs of trusts.

**Learned, not taught**

I do not think that leadership can be taught, in any formal sense, but it can be learned if leaders set a consistent example. It is a state of mind, based on a set of beliefs about what is right: a firm sense of what matters and what does not; the ability to make decisions and accept responsibility for the consequences; having a vision of where the team is going and the guts to stand by your principles. Like charity, ‘it is not puffed up, it suffers long and is kind’. It encourages leadership in others, backing initiatives by other members of the team but maintaining sufficient distance to evaluate and correct the course when necessary. Leaders are not paid to be loved. It is easy to say this lightly but leadership is, in fact, a lonely place. We must be approachable and encourage others to speak out, but we can never forget that the pips are on our shoulders and one day we may have to deal with our most promising junior in a formal disciplinary setting. Some distance is needed: to paraphrase Machiavelli in *The Prince*, ideally, leaders should be loved and feared, but if you have to choose, then you must choose to be feared.

Leaders know the rules, the limits of their jurisdiction and the personal vulnerabilities and strengths of their staff. They never put people down in public; never try to deal with underperformance in the heat of the moment; above all, they are self-critical, privately if not publicly. A leader has the confidence to accept the blame for what has gone wrong, and does not blame juniors for matters which have been delegated. If a junior gets it wrong, it is right to have them on the carpet, with or without blood, but if you decide to delegate, the responsibility is still yours. If you ever have to say ‘...because I am The Boss’, you have just proved that is not how people see you in practice. On a simple, physical level leaders look people in the eye, walk confidently and stand tall, even if they are only five foot two. Then there is the grind of leadership, carrying on doing it day after day, attending to the detail, dealing with others less motivated and keeping smiling, however fed up you feel.

**The patient**

As patients, we are never more vulnerable than when, through illness, accident or proximity to death, separated from relatives and friends, we are ‘under the doctor’, as we say in Glasgow. At such times all our pain, fear, comfort and self-respect are at the mercy of doctors, nurses, care workers, orderlies, physiotherapists, pharmacists and clerical workers. So as patients we need to feel that there is ‘someone in charge’, someone upon whom we can rely to lead us safely through whatever is to come. Hospital departments and individual wards vary considerably in projecting an ethos of care and professionalism, as do GP surgeries and care homes. I am convinced that the best are guided by strong leadership, leading to coherence of the standards maintained by all the staff.
The College regularly receives enquiries from individual doctors and appraisers seeking advice on revalidation and clinical standards. This article summarises how these enquiries are dealt with and the workings of the Revalidation Specialty Advisory Team.

The medical royal colleges are a valuable source of information for responsible officers (ROs) and appraisers/clinical leads faced with a doctor with possible performance concerns. The Academy of Medical Royal Colleges has therefore asked the colleges to set up systems for providing specific help.

We would also anticipate that now the process of revalidation has been introduced then enquiries would come directly from individual doctors. We envisage that requests for advice will fall into six main categories:

- **The revalidation process**
  - Return to work, doctors working overseas, independent practice, locum work.

- **Issues arising from appraisal**
  - Appraisal process, scope of practice, training for appraisers.

- **Continuing professional development**
  - The CPD Matrix.
  - CPD credits, personal development plans.

- **Review of clinical practice**
  - Clinical audit, outcome data, case reviews and significant events.

- **Feedback on clinical practice**
  - Colleague, patient and teaching feedback, complaints and compliments.

- **Performance concerns**
  - Performance issues, probity, health, remediation.

The helpdesk
We have established a helpdesk, which can provide generic advice and can get help with specific circumstances. Questions regarding the processes underpinning revalidation, or help with finding the relevant guidelines and regulations, will be answered by non-clinical staff in the Revalidation and CPD team, and can normally be dealt with very rapidly. Questions that require clinician input will be referred to the Revalidation Specialty Advisors for reply – this may take a little longer.

**Figure 1** RCoA model for considering enquiries relating to revalidation

<table>
<thead>
<tr>
<th>Enquiry or request for advice</th>
<th>Is the enquirer seeking clarification or authoritative opinion on a specialty standard?</th>
<th>Seek expert opinion from revalidation specialty advisors in formulating a response</th>
<th>Check national (e.g., College, Faculty) standards documents and guidelines before responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this question about a process relating to revalidation, e.g., supporting information requirements?</td>
<td>Refer to GMC, Departments of Health and College guidance and requirements</td>
<td>Check website FAQs to ensure consistency when responding</td>
<td></td>
</tr>
</tbody>
</table>
The revalidation specialty advisors
The College has established a team of 19 senior clinicians to act as advisors. Between them they have a wide range of clinical expertise, including anaesthesia, pain and critical care, and they are located across the UK. The advisors have been trained in the processes, and attended a training day at the College in November 2012. It is intended that the advisors will meet once or twice a year to share their experience.

Advisors are intended to give informed and impartial advice relating to specialty standards, issues and areas of practice. They may be of particular value when the RO or appraiser is not a doctor practising in anaesthesia, intensive care or pain medicine and is in need of informed advice.

Enquiries referred to the specialty advisors will be anonymised by the helpdesk; the advisors will be unaware of the identity of the individuals concerned, or their hospital, and the identity of the advisors will be removed before the advice is issued. To avoid any possible misunderstandings or ambiguities then all correspondence must be in writing (by email). The College will keep a record of all correspondence for audit purposes. Whenever possible we will send an enquiry to two advisors, so as to give a balanced view.

Scope and liability of College advice
The College cannot become directly involved in the decision-making process regarding a revalidation recommendation. It cannot instruct an RO to come to any particular outcome, since this is the responsibility of the RO. However, it can provide advice on the standards expected by the College in a given situation or set of circumstances.

Advisors will act in good faith, but it is inherent in a process like this that there could be differences in opinion or interpretation. The College, through the Academy, has taken legal advice on the possibility of a legal challenge for negligence, and already has indemnity arrangements in place to cover this unlikely eventuality.

When there are significant concerns about fitness to practise it may be appropriate to make use of processes that are already established. This may include direct referral to the GMC, arbitration by NCAS or an Anaesthesia Invited Review (ART). If an enquiry does raise these concerns then it can be reviewed by the Director of Professional Standards at the College, who will be able to give relevant advice.

Contacting the helpdesk
All enquiries should be made by email and sent to revalidation@rcoa.ac.uk. The helpdesk can be reached by phone (020 7092 1699/1729), and staff on the helpdesk may be able to help you document your enquiry, but we can only send an enquiry to the specialty advisory team when it is received in writing.

Additional information is available from the College website at www.rcoa.ac.uk/revalidation.

Reference
1 The role of the responsible officer: closing the gap in medical regulation – responsible officer guidance. DH, London 2010.
In the May 2012 issue of the College Bulletin we announced the publication of a Department of Health report on remediation, paying particular attention to the recommendation that: ‘Colleges should produce guidance and also provide assessment and specialist input into remediation programmes.’ An Academy of Medical Royal Colleges working party was convened to consider the implications of this recommendation and report on the future roles for colleges in the remediation of doctors. The Academy’s report was released in September 2012 and what follows is a summary together with the College’s latest thinking and arrangements for remediation.

**Specialty standards**

With the launch of revalidation, employers are increasingly aware of good clinical governance and the need to demonstrate that they are tackling performance concerns in their organisations. At the same time the College does have a responsibility in maintaining and advancing standards of practice in anaesthesia, so we do have an interest when performance concerns lead to these standards not being met. This reason alone justifies our involvement at national levels in planning for remediation.

At the same time we are conscious of the legitimacy of our actions in both the remediation and revalidation of doctors. The College is not a regulatory body. Our advice and guidance are not mandatory to follow and we cannot make a direct judgement that a doctor is or is not fit to practise after a programme of remediation and should or should not be recommended for revalidation by the GMC. These judgements can only be made by the responsible officer (RO) for a doctor’s NHS trust or designated body. The College is, however, asked by regulators and employers to provide authoritative opinion in reviewing the work of doctors against standards in the specialty. Examples of this include GMC Fitness to Practise proceedings and through Anaesthesia Review Team (ART) visits to departments. In the near future ROs may ask us to provide authoritative specialty opinion where an aspect of a doctor’s practice requires remediation which, if not addressed, could affect their progress towards revalidation.

**College input sought by ROs**

The Academy report indicates that there are three main areas where ROs would particularly welcome input from colleges:

1. Opinion as to whether clinical incidents, complaints or clinical outcome data are within the range of normal for the specialty, and whether or not there is a risk to patient safety.
2. Specialty guidance and resources to support a doctor in addressing an early performance concern.
3. Help with arranging external placements for a supervised programme of retraining or professional development.

Through its invited review mechanism – the ART service, the College already has substantial experience in the first two of these areas – the service in most cases goes well beyond just offering guidance and a professional opinion. When invited by employers, or by partner organisations such as the National Clinical Assessment Service (NCAS), the ART service undertakes a thorough independent review of an anaesthetist’s work and any impacting team, department or wider organisational issues. Where necessary we provide professional input in developing recommendations to address performance concerns, taking into account any contextual factors. The success of any resulting
action plan, based on our experience, is nearly always dependent on the insight of those involved and their willingness to engage actively and meet the objectives in the plan. At the same time, close colleague support and the availability of mentors and supervisors are also keys to success in the remediation of individuals.

Any direct involvement of the College in a process of remediation of a doctor should always be at the invitation of or commissioned by an RO, employing body or organisation like NCAS. The ART model and process will continue to be the main pathway in providing our professional input. The Academy report did recommend that colleges providing invited reviews should as a group agree to a set of principles in quality assuring these services so they are consistent across the medical profession. We will be working with our sister colleges to take forward this work.

With regard to arranging external placements for remediation purposes, this is something in which the College has not previously been involved. We see this responsibility as being in the remit of organisations such as NCAS, who already have a formal network of contacts in arranging placements in clinical departments and in organising the supervision and monitoring of doctors. The process of setting up, implementing and evaluating an external placement is challenging due to the costs involved and the intensive level of input required by those organising and monitoring the placement. As such, we feel that the College is not well placed to provide this particular service. The NHS Revalidation Support Team has proposed that ROs co-operate at a regional level to develop Professional Support Units. These units would make effective use of local knowledge and resources in the region in organising and co-ordinating placements, bringing expertise in from colleges, NCAS and GMC Employer Liaison Advisers when necessary.

**Prevention**

The Academy report does consider the need for prevention – in reducing the likelihood of future performance concerns and taking action in ensuring an early/low level concern does not escalate to something much more serious. Most at risk are doctors facing the stressful demands that come with being appointed to their first career grade/consultant position, or international doctors new to the ways of medical practice in the UK. For these doctors there is undoubtedly a need for structured support from mentors based in the hospital. This local in-house approach to mentorship is something this College supports and promotes and we are aware of the excellent work of the AAGBI Support and Wellbeing Committee in this area.

In addressing early or low level concerns an intensified, enhanced or targeted plan of CPD or retraining might initially be more appropriate than a more formal programme of ‘remediation’. This CPD plan would normally be initiated and evaluated by the doctor’s appraiser, having become aware of this concern during the appraisal. Where necessary, appraisers should be able to seek advice from colleges as to the objectives for the CPD plan or guidance on available specialty educational resources, tools and activities. Partly in expectation of being approached by appraisers, the College has set up a revalidation specialty advisory team comprising experienced clinicians to provide advice and guidance.

**Changing career**

The Academy report employs a traditional, and some say a medical, model in conceptualising the remediation process for doctors, i.e. diagnose (assess the reasons for and extent of the problem), prescribe a solution (remediation programme) and cure (return to unsupervised work). In some cases this model may not be applicable and it has to be accepted that it is just not possible to remediate some doctors due to the extent of their performance problems, compounding factors and unwillingness or inability to address these issues. Inability to help identify a ‘cure’ should not reflect badly on those personally involved. The role of the ‘remediator’ can be emotionally draining and it is important to understand that a doctor’s failure to remediate is sometimes the most suitable outcome. In these situations the best advice and support that could be offered is in directing a doctor away from a career in medicine.

Further information about the Anaesthesia Review Team service can be found on the College website at www.rcoa.ac.uk/governance-and-support/invited-review-art. Enquiries to the Revalidation Specialty Advisory Team should be in writing and emailed to revalidation@rcoa.ac.uk.

**References**


Patient feedback for revalidation

Patient feedback, for the purposes of revalidation, quality improvement or self-reflection, may be measured in three main ways: using patient experience tools, by measuring patient reported outcome or satisfaction, and finally, by seeking patient feedback on communication and interpersonal skills.

Information on the patient ‘experience’ is sought intermittently, but systematically, via mechanisms such as the NHS Inpatient Survey, which is conducted by the Picker Institute Europe.¹ In this, patients are asked to comment on a variety of elements of their total NHS experience, including the attitudes and professionalism of staff, the cleanliness and ambience of their environment, and the efficiency and safety of their transit through the hospital. While this information provides important feedback for trusts as a whole, there are few questions directly related to anaesthesia care, and the information is anonymised so that neither the patient nor individual practitioners can be identified.

Second, since the 2008 publication of ‘High Quality Care for All’ (colloquially known as the ‘Darzi report’), there is an increased drive to collect patient reported outcome measures or PROMs.² These are questionnaires which focus on health-related quality of life, and which patients are generally asked to complete twice: once immediately before a planned intervention, and again some time later (usually after six months). This enables the measurement of change in the patient’s perceptions of their health, and thus the success (or otherwise) of the procedure. There are four surgical procedures in which the Department of Health has mandated PROMs questionnaires be provided to patients in all hospitals – primary hip and knee replacement, and varicose vein and groin hernia repairs. The PROMs programme is expected to expand to include coronary revascularisation, and long-term conditions in the near future.

For anaesthetists – while there are no specific PROMs – patient satisfaction questionnaires or quality of recovery scores may be viewed as alternative methods of measuring the patient’s perception of the quality and outcome of delivered care. While some departments measure these data sporadically, we are a long way from systematically recording and reporting these outcomes (see HSRC outcomes working group report on page 19). Finally, we can ask the patients for feedback on our communication and interpersonal skills; this type of feedback is the focus of the rest of this article, and also of newly published College guidance at www.rcoa.ac.uk/node/10208. We should be collecting this information by using any one of the multi-source feedback instruments which have been developed by the General Medical Council or a number of commercial providers. The GMC has recommended, in their guidance on supporting information for revalidation, that all doctors participate in patient feedback exercises, unless there are exceptional circumstances which make this infeasible or impractical.³

Clearly, there are hospital specialties where obtaining patient feedback may be difficult or impossible – pathology or other laboratory based specialties being the most obvious. Work conducted at the Peninsula Medical School and on behalf of the GMC looking at the feasibility of obtaining colleague and patient feedback across a variety of specialties (using the GMC’s questionnaires) found that, while anaesthetists were almost universally willing and able to engage with obtaining colleague feedback, approximately half struggled to obtain the required number of patient feedback forms to enable a valid assessment.⁴ While it is clear from this study, and indeed from clinical experience, that there are challenges for anaesthetists in obtaining patient feedback, surely we do not want our specialty to be put in the same ‘too hard to do’ category as other groups whose patients are dead or represented by test-tubes?! Furthermore, it is recognised both by anaesthetists and by lay
representatives on our Patient Liaison Group, that anaesthetists require excellent communication skills in order to gain a patient’s trust in a relatively short period of time, and provide reassurance and calm at a particularly anxiety provoking time in the patient’s hospital experience.

Therefore, a working group of anaesthetists and lay members have produced guidance to help anaesthetists meet the challenge of obtaining patient feedback for revalidation. This is an update on the previously published guidance for collecting peer and patient feedback, and the main essence of it is a list of principles that should help to steer departments and individuals through the practical challenges of obtaining patient feedback.

In the discussions which led to this document, we considered carefully whether there was a requirement to develop an anaesthesia-specific feedback questionnaire, and have decided against this for a number of reasons. First, the process of developing, validating and subsequently implementing an anaesthesia-specific feedback instrument would require considerable resources, for limited potential benefit. There are a number of advantages in using the GMC or commercially provided instruments: each of these providers has already set up a system for the collection and confidential reporting of patient feedback; the questionnaires have been developed in a scientifically valid process, and many trusts have already entered into contracts with commercial providers which mean that their employees can obtain this feedback (as well as colleague multi-source feedback) at little or minimal personal expense.

Second, we do not consider anaesthesia to be sufficiently ‘different’ from other hospital specialties with respect to the doctor-patient interaction, to necessitate a unique feedback instrument. The main areas which such feedback seeks to evaluate are: clarity of communication, politeness, compassion and the extent to which the patient feels involved in their own care. The first three are key tenets of a good doctor-patient relationship; the fourth poses similar challenges for all doctors.

A prime consideration for the College, and for appraisers, should be ensuring that the benchmark against which an anaesthetist is compared, is limited to the results from fellow anaesthetists, rather than against other specialties where the doctor-patient relationship may have a different nature (such as those providing on-going care in the primary care setting).

Discussion with colleagues informs us that many (possibly most) consultant anaesthetists have participated in colleague multi-source feedback and found this to be a reasonably straightforward process. Therefore, the guidance on patient feedback focuses on addressing some of the practical hurdles which face us. Some of the questions which we have tried to answer include: ‘when is the most appropriate time to approach patients?’, ‘how will the patient know who they are assessing?’ and ‘what systems does the department need to consider implementing in order to support anaesthetists obtaining patient feedback?’.

When considering the guidance, we urge you to adopt a ‘glass half full’ attitude.

Many hospitals specialises face difficulties in gathering patient feedback owing to the nature of their practice: emergency medicine, paediatrics and psychiatry to name but a few. The limitations of measuring our performance based on a quick five-minute consultation on the morning of surgery are well-recognised; however, GPs with ten-minute consultation limits may well also be justified in complaining that the focus on ensuring service delivery does not permit adequate time to ensure that the patient feels ‘listened to’. While it is true that the collection of patient feedback is an imperfect science, we know – because our patient representatives tell us so – that this is a fundamental area of the revalidation process with which we should attempt to engage, in order to satisfy the public. We are keen to hear your views on the guidance, and any suggestions on how it may be improved, including any practical examples of how you have implemented patient feedback processes in your own departments.

Our thanks go to the members of the working group, and in particular to the members of the Patient Liaison Group who contributed to the discussions.

Guidance for ‘Seeking Patient Multisource Feedback in the Perioperative Period’ can be downloaded from www.rcoa.ac.uk/node/10208.

References

3 Supporting information for appraisal and revalidation. GMC, London 2012 (www.gmc-uk.org/static/documents/content/Supporting_information_for_appraisal_and_revalidation.pdf).
RCoA online CPD system – an evolving resource to support revalidation

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The College online CPD system was launched in August 2011 as a ‘one stop’ solution to support consultant and career grade doctors in planning and recording their educational and professional development activities. This article describes how the system aligns to the GMC guidance on recording CPD, and details the process by which events are approved by the College for CPD credits. As there has been a significant recent increase in use of the online CPD system, information is provided on some of the quality assurance mechanisms which are used, and on two recent innovations: the PDF reporting function and the launch of the Revalidation e-Portfolio.

Recording CPD activities
The GMC requires doctors to reflect on what they have learnt from their CPD activities and record whether these have had any impact on their performance and practice. Fellows and Members using the College online CPD system can record their learning outcomes and reflections, as well as the number of CPD credits claimed, in a central and secure place. The GMC also stresses the importance of doctors compiling and maintaining a personal development plan (PDP), which should be discussed at their annual appraisal and reviewed throughout the year. Again, the online CPD system will help with this process, as it allows for PDPs to be set up which can then be linked to an anaesthetist’s CPD activities.

CPD approvals
A key element of the online CPD system is its database of approved CPD courses and events. Now that the system has become established there has been a growth in the number of applications for CPD approval, and by November 2012 the database included details of over 650, past and future, approved events.

The approvals process is commenced on the basis of an event provider making a formal application to the College, which is then evaluated by one from a number of specialist assessors appointed by the College CPD Board for their clinical expertise. All events seeking CPD approval – whether organised by the College, faculties, specialist societies or commercial providers – will undergo the same evaluation process.

When approval has been given, the online CPD system features copies of the event programmes and speakers in addition to information on how the programme material aligns to the College’s CPD Matrix – a resource designed to provide guidance on appropriate topics (knowledge and skill areas) to be covered by career grade anaesthetists. Events are fully searchable by date, title, provider or CPD Matrix topic.

The CPD approvals process is one means by which events are quality assured, and consistency of practice in the process is further monitored through internal mechanisms and the annual review of the delegate feedback summaries from a sample of approved events. Users of the online CPD system have the opportunity to rate the degree to which the intended learning outcomes were met by an event provider and to rate the event’s content and presentation, and an example screenshot is shown in Figure 1. These reviews assist the College in providing an overview of the event provider’s performance and can also be made available to the provider to help inform their future provision.

Reporting CPD activities
The online CPD system is constantly evolving to best serve the College Members’ needs. We have recently launched a new reporting function whereby a collated, summary report in PDF format can be produced of the user’s CPD activities (including their reflective notes and learning outcomes), saved and then emailed to an appraiser or uploaded into an electronic appraisal system. This new function supports one of the GMC requirements for revalidation, that a doctor presents a summary of his or her CPD activities at the annual appraisal.

There are, in fact, two reporting options: the first produces a report
listing CPD credits achieved in all categories of educational activity (for example, events and meetings, reading, etc), from internal and external sources, and clinical and non-clinical activities. Option two – the full report – is more detailed and includes the titles and dates of educational activities undertaken, together with any documented reflective notes and learning outcomes.

User survey
By November 2011 the online CPD system had 998 registered users and 12 months later this amount was approaching 3,500 users, with a strong increase in new registrations over the last few months. We recently surveyed the 1,020 Members who had used the online CPD system over the previous four weeks and asked them to rate on a scale of 1 to 5 its user-friendliness and the functions available (1 being ‘not helpful’ and 5 being ‘very helpful’). The user friendliness of the system was rated as 3 or above by 88% of respondents, whilst the same rating for the functions available had been given by 91% of those who responded.

The College maintains a log of suggested enhancements to the online CPD system and with this in mind the survey also asked members to suggest any improvements that could be made. One popular request was for an ‘app’ or mobile enhanced resource to be developed; other suggestions included a summary report linked to the College CPD Matrix and the provision of some case studies to highlight best practice in using the system or engaging in CPD in general.

Revalidation e-Portfolio launched
The College has recently launched a Revalidation e-Portfolio which is an additional Member benefit for managing and storing all the supporting information required for appraisal and revalidation. For example, the PDF summary report from the College online CPD system can be exported into the e-portfolio where permission can be set to allow an appraiser to view it. The system also allows the uploading of supporting information in respect of quality improvement activities (for example, audit) and colleague and patient feedback.

The Revalidation e-Portfolio has been developed by a cohort of eight medical royal colleges, in conjunction with Equiniti 360 Clinical, and structured according to the GMC requirements for appraisal and revalidation. It also includes, in places, help-boxes with pointers drawn from the supporting information guidance for doctors in anaesthesia, intensive care and pain medicine.

To register to access both the online CPD system and the Revalidation e-Portfolio click on the links found at www.rcoa.ac.uk/e-portfolio-and-cpd-systems. For further information, please contact cpd@rcoa.ac.uk.

Reference

1  Continuing professional development – guidance for all doctors.  GMC, London 2012.
Revalidation e-PORTFOLIO

FREE ACCESS FOR FELLOWS AND MEMBERS

The Revalidation e-Portfolio provides doctors with an easy-to-use, private and secure online space for storing and managing all supporting information required for appraisal and revalidation.

“We hope that Fellows and Members will benefit from using the e-Portfolio when reviewing and reflecting upon their work. Doctors will have control over third party access to supporting information for appraisal that is stored in the Portfolio.”

Dr Peter Venn
RCoA Council Member and Revalidation e-Portfolio Lead

Accessing the Revalidation e-Portfolio
RCoA, FICM and FPM Members can self-register to set up an account to access the Revalidation e-Portfolio.

To do this go to: www.rcoa.ac.uk/e-portfolio-and-ep-systems

You must have your GMC and College reference number to hand to self-register.

For further information contact: revalidation@rcoa.ac.uk

The Revalidation e-Portfolio is:

- Free to all subscribing Fellows and Members of the RCoA, FICM and FPM.
- Customised for storing and managing supporting information privately or outside a doctor’s workplace.
- Easily accessible online so that users can upload and retrieve data anytime, anywhere.
- Useful for doctors working for more than one organisation or moving between employers allowing them to take their supporting information with them.
- Accessible by an appraiser and responsible officer given permission by a doctor to view their supporting information online.
- Structured and aligned with the requirements for revalidation as specified by the General Medical Council.
- Intended to be helpful through links to key RCoA, Academy, GMC and UK Departments of Health guidance on revalidation.
- Developed by a cohort of eight medical royal colleges representing most secondary care specialists.
- Secure and compliant with data protection legislation and the rules of the Information Commissioner’s Office.
- Fully incorporated into Equiniti 360° Clinical’s Revalidation Management System designed to help trusts and boards manage the revalidation process.
Maternal critical care
Care worthy of the name?

Do you manage critically ill mothers during pregnancy and labour? Are you frustrated with deficiencies in the quality of care? Are we compromising our standards of care by allowing sick mothers to stay on the maternity unit (compared with the care given on a critical care unit with appropriately trained staff and facilities)? In this article we address the scope of the problem, the current evidence and areas for improvement emphasising the key role of anaesthetists in implementing changes.

Increasing numbers of sick mothers with more complex problems are being seen on isolated maternal critical care (MCC) units. These units operate outside the standards and guidelines of the critical care environment and manage a wide spectrum of critically ill obstetric patients, and mothers who may or may not have had a ‘high risk pregnancy’. The obstetric anaesthetist is the key player in developing a model of care that works in individual hospitals linking into and organising the necessary groups.

Scope of the problem
Increasing numbers

The latest confidential enquiry1 shows a significant number of deaths associated with suboptimal care of the critically ill mother and, in particular, an increase in deaths from sepsis and genital tract infection. Between 2006–08 there were 29 deaths from sepsis, including 13 direct deaths from Streptococcus pyogenes genital tract sepsis in pregnancy. Lack of recognition of the signs of sepsis and a lack of guidelines on its management were both identified as problems in the report. Risk factors for sepsis include obesity, diabetes, anaemia, history of pelvic infection or Group B Streptococcal infection and black or minority ethnic origin. In April 2012, the RCOG published ‘green top guidelines’ on managing bacterial sepsis during and following pregnancy2,3 on a background of increasing national and international awareness of the seriousness of the problem in the population as a whole. The Sepsis group4 and the Surviving Sepsis Campaign (SSC), developed by the European Society of Critical Care Medicine, the International Sepsis Forum, and the Society of Critical Care Medicine, have identified the problem to be more common than acute coronary syndrome and more deadly than stroke. These groups are working to meet the challenges of sepsis and to improve its management, diagnosis, and treatment in all patients including obstetrics.

More complex cases
Clinicians are now facing increasingly complex medical and obstetric problems. For every death there are at least nine women who develop severe maternal morbidity. The Intensive Care National Audit and Research Centre (ICNARC) has been collecting data on critical care admissions of pregnant women since 2006. The latest report5 shows that 11.4% (513) women aged 16–50 years admitted to ICU in the UK were obstetric patients and the majority were ‘recently pregnant’ (418) versus ‘currently pregnant’ (95). The main obstetric cause of ICU admission in ‘recently pregnant’ was haemorrhage, and pneumonia was the major reason in ‘currently pregnant’ (95). The ICNARC numbers translate to 2.4 ICU admissions/1,000 maternities. Moreover, the incidence of Level 2 care (ICS classification) can be up to 20 times Level 3 care needs1 and this is usually delivered within the maternity unit. The Scottish Confidential Audit of Severe Maternal Morbidity (SCASMM)6 identified 1.4 ICU admissions/1,000 live births and a rate of serious morbidity of 5.7/1,000 deliveries.
Critical care training for midwives, obstetricians and obstetric anaesthetists

Midwives are no longer nurses; most midwives in practice now come via a direct entry degree course of three to four years. There is a strong focus on studying ‘normality’ in pregnant women, and the undergraduate curriculum does not address the specialised training required for looking after critically ill parturients. This is compounded by a national shortage of midwives and a higher proportion of maternity support workers.

Early specialisation and ‘streamlining’ of obstetric training in the UK add to the issue as obstetric trainees do little general medicine training. After two years of foundation training, trainees apply for a seven-year ‘run-through’ in obstetrics. There is minimal MCC in the obstetric core curriculum.

Historically, obstetric anaesthetists have undergone training in intensive care medicine (ICM) similar to colleagues taking up posts in smaller intensive care units. In August 2012 it became possible to train solely in ICM and, although consultant obstetric anaesthetists will still receive training in ICM, they will not be trained to deliver the same level of critical care as future intensivists. Interestingly, approximately half of those appointed to the new ICM training posts this summer did not come from an anaesthetic background and therefore may be unfamiliar with current obstetric anaesthetic practice.

Maternal critical care (MCC) is a sub-speciality where many disciplines are required to define their remit, limitations and professional standards. Clinical staff looking after such a unit should be suitably trained, maintain CPD, have allocated time in their job plans and work with the rest of the hospital’s critical care service.

The former Joint Standing Committee’s document, ‘Providing Equity of Critical and Maternity Care for the Critically Ill Pregnant or Recently Pregnant Woman’ PECCW, aimed to summarise existing standards in not one but many models of care to take into account local variation in training and facilities. This publication recognised various models of care working throughout the country but underlined the need to ensure standards are being met.

The current evidence

MCC unit models

The Department of Health’s document ‘Comprehensive Critical Care’ in 2000 stated that care of the critically ill patient should be of a high standard irrespective of the location of the patient within the hospital—the so-called ‘critical care without walls’. Unfortunately, the funding and initiatives for critical care teaching training and audit were not taken up by obstetrics in many hospitals. Maternity units often function as a separate site within the hospital and have their own guidelines, managing the majority of maternal critical care cases. There are many models of care depending on the size of unit, numbers of high risk patients, facilities and staff training. Some units transfer all critically ill patients, some manage certain cases especially pre-eclampsia and massive haemorrhage. Often larger centres (Liverpool, Birmingham, Leeds) manage the vast majority of critically ill cases (around 5% of deliveries) in their own units.

Auditing standards – a pilot scheme in Yorkshire

Critical Care Networks exist in 27 regions throughout the country. Key intensive care unit members from the various trusts meet regularly to discuss critical care issues and changes on a regional basis (although this is currently under review with the imminent changes in NHS funding).

Since October 2010 the West Yorkshire Critical Care Network has supported a maternal critical care group that meets four times a year, chaired by an obstetric anaesthetist (AQ), MCC@WYCCN. Key representation within the group includes obstetric anaesthetists, obstetricians, intensivists, midwives, critical care and outreach nurses and clinical educators from each trust with links to the maternity forum of NHS network and Chief Nurses group. Earlier in the year the Yorkshire and Humber NHS Network supported the MCC@WYCCN in a benchmark of important sections from PECCW including: examination of physiological observations (MEWS); response strategy (track and trigger); handover of care on ward; competency trained staff; obstetric input on general ICU; documentation of multidisciplinary working; care bundles, e.g. sepsis care bundle; separation of mother and baby; VTE prophylaxis; and patient feedback on critical care experience. An audit was carried out in the 15 trusts within Yorkshire and Humber NHS resulting in the following action plans/recommendations being developed:

▶ Improved education around sepsis.
▶ Ensure early warning scores and protocols for escalation are in place and regular audit of obstetric areas to encourage compliance.
▶ Encourage obstetric staff to attend a course with ABCDE approach to recognising acutely ill patients, e.g. ALERT, AIM, PROMPT, REACTS.
▶ Promote links between obstetric departments and critical care/outreach.

Importantly, in recognition of the lack of staff with HDU competency training identified generally throughout the region, the group are working on MCC...
competency teaching, training and audit documentation and policy, to be ratified on a regional basis based on the new national HDU competencies published in December 2012.

Areas for improvement
Critical care funding
Each designated critical care unit within a trust records the level of care for a given patient using the critical care minimum dataset, CCMDS. This is roughly translated into PBR, Payment by Results. Payments in obstetrics are different and are in broad groups – for vaginal delivery, caesarean section and high risk pregnancy – but there is no breakdown for the level or intensity of nursing care in a severely ill patient. Imminent changes to the NHS funding may provide an opportunity to identify a revenue stream to establish and support high quality maternal critical care teaching and training. Maternity services constitute one of the four new NHS Senates and the maternity pathway tariff for mothers requiring ‘intensive postnatal care’ has been highlighted in www.dh.gov.uk/en/Publicationsandstatistics/publications/PublicatinPolicyAndGuidance/obstetrics. The new tariff aims to encourage normal births but, in recognition of the high risk patients, an extra £825 is available if they require intensive postnatal care.

Achieving ‘designation’ for any maternal critical care unit would be difficult as certain numbers and levels of intervention (e.g. invasive lines) are required (less frequently used in obstetrics). Other units, e.g. coronary care, receive extra funding without ‘designation’ and this method may be more applicable to MCC. Whatever the route, anaesthetists are a crucial link between the specialties of obstetrics and intensive care and should be involved in MCC funding discussions both at national and local levels.

Teaching and training
Obstetric anaesthetists have several resources to maintain their skills in MCC such as MOET, MOSES and PROMPT courses, the Obstetric Anaesthetists Association (OAA) and the Royal College of Anaesthetists (RCoA) study days on MCC and several simulator based regional courses on obstetric anaesthesia. However, the training deficits are often at the midwifery and nursing level on our maternity wards (our obstetric anaesthetic trainees will verify this) and we need to address this.

This should include training in early recognition of acutely ill and deteriorating patients and their initial resuscitation. Midwives should be competent in recording MEOWS as suggested by NICE and escalating care using the track and trigger system. Here the link between the obstetric anaesthetist, the intensivist with obstetric interest, obstetricians, midwifery and critical care staff is important.

Only a few units around the country have HDU trained staff available to care for sick mothers. The Scottish Multiprofessional Maternity Development Group (SMMDG) (www.scottishmaternity.org) has been developed to co-ordinate training (REACTS) for all healthcare professionals who participate in the care of pregnant women. We need to encourage our obstetric colleagues to develop an MCC sub-specialty interest with rotations to ICU during their
training. The obstetric anaesthetist can liaise with critical care and outreach to support midwifery in establishing critical care teaching and training as well as helping to develop their own in-house courses. The PECCW document provides a suggested core curriculum and courses, appendices 8 and 9.

A university course
The Care of the Critically Ill Childbearing Mother (CCICM) at Leeds University is a unique postgraduate course in the UK specifically for midwives interested in MCC. The PGCert comprises pre-course preparation material in the form of video podcasts, followed by a training day with simulated scenarios, case discussions and resuscitation training including obstetricians, midwives and anaesthetists. Funding for midwives comes from the strategic health authority. The same course material is mandatory training for trainee obstetricians in the Yorkshire obstetric postgraduate training scheme. The course provides a theoretical basis for clinical skills training without too much initial study leave, but requires continued commitment and investment by all concerned.

Summary
A safe environment is fundamental to optimal patient care. In the case of patients requiring a high level of organ support, Level 3 care should be provided in a general intensive care unit. Normal mothers should be cared for in a ‘close to normal’ environment. This article considers ways to manage the sick obstetric patient requiring Level 1 or 2 care. Suitably trained obstetric anaesthetists are best placed to lead the development of MCC owing to their range of skills, including resuscitation and management of critically ill patients but all members of the team need to recognise deficits in training and potential challenges ahead.

Many countries outside the UK practise different models of care; in these countries patients requiring a higher level of care go to the main HDU/ICU. UK culture is different with sicker patients being cared for on the delivery suite. It is important to recognise the advantages and disadvantages of this so that our sickest patients get the best care. The Obstetric Anaesthetists’ Association is currently setting up a multi-disciplinary maternal critical care subcommittee to examine and guide practice in this area.

For the obstetric anaesthetist, contributing to a quality MCC service should be an overall rewarding experience with motivated staff and facilities similar to those in units for non-pregnant patients. This should be the aim of all obstetric units managing increasingly complex cases needing higher levels of care. Adequate time and resources for this should be identified and assigned in job plans. With increasing recognition and expansion of the sub-specialty of maternal critical care this will hopefully become an easier task. It will be important to promote links with critical care and outreach services to help ensure staff are adequately trained in early recognition of a critically ill parturient and to optimise the use of physiological early warning systems to increase safety on the delivery suite. We need to recognise that patients admitted as ‘low risk’ may subsequently deteriorate on a postnatal ward. The incidence may be small but a sick mother and her newborn deserve the best care in UK hospitals. National audits continue to indicate there is room for improvement.

Acknowledgements
Karen Dearden (Network Lead)
Margaret Clark (Network Manager)
Kathy Smith (Group Coordinator)
West Yorkshire Critical Care Network, Dewsbury and District Hospital

References
4. The Surviving Sepsis Campaign (www.survivingsepsis.org/About_the_Campaign/Pages/default.aspx).
There are 750 e-Learning Anaesthesia sessions now available on-line for training and revalidation.
The introduction of any new process can be filled with apprehensions and anxieties associated with the changes it brings. The introduction of the e-portfolio was not an exception in that aspect. That this change came along at a time when trainees and trainers were getting to grips with the new curriculum made it even more challenging. Migration to the e-portfolio involved a major change in how all the documentation was going to be assessed, collated and stored for future ARCPs and eventual progression through training, so it was reasonable for all parties involved to be a little anxious.

**View from the e-ARCP panel**

South East Scotland was one of the three pilot deaneries for the e-Portfolio (ePF). In January 2011, after a couple of training sessions by the College ePF team, all trainees on the August 2010 curriculum were instructed to use it to collect evidence.

Despite not being the remit of the pilot project, we ran our June/July 2011 ARCPs using a combination of electronic and paper evidence. The main problems we identified in 2011 were:

- The tasks for each panel member were delegated beforehand, but due to access to a single sign on to ePF on the day and no preview before the ARCP, reviewing each trainee’s portfolio by the whole team was very time consuming and disjointed.

- Allowing the use of electronic and paper evidence meant most trainees and trainers defaulted to the paper version.

However, we were pleasantly surprised by the number of trainees on the 2010 curriculum who had embraced the e-portfolio and had all their evidence there to be reviewed.

On the basis of the identified problems we devised the following strategies for our 2012 ARCPs:

- A clear deadline date was set for the trainees to assign evidence from their portfolio to the ARCP panel, which would be set up by the deanery training support officer.

- The panel members’ tasks were delegated again and access was given a week prior to the e-ARCP by the deanery administrative staff, so that each member could concentrate on reviewing the evidence in advance. The external assessor took on the role of critiquing the trainees’ CVs, which were uploaded in the ePF by the trainees. This was the one area where it was felt appropriate to use a paper copy. The external assessor found this useful in that he could write comments and rearrange the layout of the CV. That copy was returned to the trainee at the face to face meeting. It is our practice to invite all trainees to meet with the ARCP panel after the review of evidence and outcome allocation.

There was near 100% achievement of trainees getting their evidence assigned before the cut off date. The few that missed were almost invariably related to difficulties meeting with their educational supervisor to complete the ESSR.

**Logistics on the day**

The training programme support officer ensured that there were at least three computers (desktops and/or laptops) available to the panel with access to the ePF of all trainees being reviewed. We worked off one computer, with projection of the ePF of the trainee being reviewed on a giant screen in the room. The ESSR was screened in front of the whole panel. This was summarised by the
regional advisor. Other panel members then fed in information on the areas they had focused on. This led the panel discussion towards areas of potential weakness, e.g. log book numbers, gaps, number of units of training completed, MSF outcomes, consultant feedback and also the personal development plan for the year ahead.

If there were any areas of contention it was possible to bring up more evidence, e.g. an MSF or WpEAs, from the same portfolio on a second computer. Carrying out the review process in this way enabled us to review the evidence of all trainees in the time allocated.

**Difficulties encountered**

These were mainly related to IT issues and problems that individual trainees had uploading data. Some trainees had scanned/uploaded their ESSR one page at a time which made it more cumbersome to read through, as this necessitated closing down and then opening each single page rather than opening the whole document.

Handwritten educational supervisors’ reports and other evidence often did not scan well and were illegible in a few cases. These were deemed not acceptable for future years.

The above problem would be solved with provision and use of electronic ESSR on the ePF by December 2012.

**Final comments**

It is increasingly obvious that there is a significant amount of SPA time required for an educational supervisor to interact adequately with their trainees to produce a report that is robust and is able accurately to inform an ARCP panel; however, once the system is completely electronic, including ESSR and unit of training sign off forms, the process will become much simpler and less time consuming.

We would also reiterate the fact that it is essential that the ARCP panel has access to the evidence before the actual ARCP day and decides which areas of evidence the individual panel members are going to review in advance and summarise on the day. This strategy makes it possible to cover the evidence presented in a controlled, in depth fashion.

**View from Postgraduate Training Support Unit**

A great part of the success of the e-portfolio introduction in South East Scotland can be attributed to the training support personnel.

They have supported the users since the beginning of the pilot phase. A dedicated email account was set up for problems related to ePF which meant that new users could contact the unit with any issues. If the issues were technical, rather than user based, the unit liaised with the e-portfolio team at the College.

**e-ARCP process**

Setting up an ARCP panel is very easy and takes no longer than two hours. This includes adding the panel and setting the ARCP dates on each trainee profile. A combination of using the e-portfolio and informing trainees of their reviews via email rather than by letter has greatly improved efficiency and reduced reams of paper being used for the same process.

**Training**

From a setting up point of view, we feel it is very important that the admin staff engage in the e-portfolio. We can advise other interested deanery staff on how to use the system, be a conduit to the team at the College and encourage the clinicians to use it. If we (administrative staff) are comfortable in how the system works then it is easier to use and administer.

**Views from the trainees’ perspective**

Finding detailed information about pros and cons of the new electronic system from everyone involved was not an easy task purely because ARCP itself is a complex process involving communication and co-ordination at multiple levels. We therefore conducted a deanery-wide survey of educational supervisors (ESs), College Tutors (CTs) and trainees to inform us on specific components of the e-portfolio as well as the impact of e-portfolio on the whole ARCP process. To gain a broader insight into related concerns we added a ‘free text area/comments’ with each question. Out of 95 trainees in the deanery to whom the survey was sent we received responses from 71 trainees, giving us a return rate of about 75%.

The following paragraphs are excerpts from the survey.

**e-ARCP functionality – organisation and efficiency of procedure**

![Figure 1 e-ARCP functionality – organisation and efficiency of procedure](image)

Success of ARCP depends upon organisational skills and efficiency in which trainee has gathered and collated their documentation.

Q. Do you think use of e-portfolio has made you:

1. More efficient, more organised
2. Less efficient, less organised
3. More organised but less efficient

As can be seen from Figure 1 the majority of the trainees felt that gathering and collating documentation for the e-ARCP process was better than the paper based ARCP. Interestingly, almost a third of respondents thought that despite the e-portfolio improving organisation, it actually made them less efficient. Reasons cited for this included:
The need to scan in many documents and save them under various categories in the library.

- Difficulties in linking scanned paper assessments and documents to the ARCP record.
- Limited access to computers and scanners in the workplace.

In general there were many comments of optimism that the process would become more efficient once it is 100% electronic. New functionalities have since been added to the ePF and now all documents can be associated with the ARCP record and there is an electronic completion of unit of training sign off form.

**ARCP – documentation workload**

The general comments in the section were favourable. Some trainees suggested that the anaesthetic e-portfolio was better than the ones used by certain other specialties!

**Workplace based assessment tools functionality**

This is one of the most frequently visited areas of e-portfolio and the core building block of the portfolio itself. We received a lot of free text comments with valuable feedback in various areas. The majority of the objective responses (as in Figure 3) about functionality of this component ranked between good and excellent.

Freehand comments for further improvement included:

- No inbuilt email reminder service for the assessor to complete the pending WpBAs. Some trainees commented this to be the key factor for reducing their efficiency as the process made them dependent upon the efficiency and organisation of the assessor.
- Inability to link the scanned paper based WpBAs to the ARCP record.
- Lack of actual discussion pertaining to the assessment before it is signed off as satisfactory or unsatisfactory. Assessors were reported writing comments in the given areas in WpBAs rather than having actual feedback discussion with the trainee, a key element in trainees’ summative learning.

We suggest a few pragmatic solutions from the survey and general feedback.

- It is imperative for the deanery to remind the users (both trainees and trainers) to access the system regularly.
- Once all the assessments are completed electronically, there will be no problem linking them to the ARCP record.
- The College has recently introduced a facility allowing trainee and assessor to sign on and combine discussion, feedback and completion of the assessment. This however does require access to a computing device and time for discussion together. The use of portable devices (e.g. tablets) also was amongst suggestions for solutions.

**Figure 2 ARCP – documentation workload**

A considerable amount of documentation and a comprehensive list of material is required to be submitted by trainees near ARCP.

Q. Do you think with e-portfolio your overall workup for producing evidence has been:

1. Easier
2. More difficult
3. Made no difference

The respondents in this part of the question were divided into three groups. More than half replied that the documentation workload was easier as compared to a paper based ARCP process. Comments from those who found it more difficult included:

- Difficulties with assessors not being registered on the e-portfolio.
- Difficulties in tracking the progress of MSF responses.
- Difficulties in uploading anaesthetic logbook summaries.

Acute Common Care Stem (ACCS) trainees face particular difficulties. Assessors from related specialties (emergency and acute medicine) are not registered on the e-portfolio. This means resorting to paper based assessments.

**Figure 3 Workplace based assessment tools functionality**
Overall, the feedback gathered from the trainees in our region seems positive for most functionalities of the system. However, there are certain areas that need to be improved.

**e-portfolio training: trainee led, the way forward**

A key element to the success of e-portfolio in our region was hands-on training sessions delivered by the end users (trainees) themselves at regular intervals throughout the year. We also suggest that a dedicated e-portfolio training session should form a mandatory part of all trainees’ induction. Both these steps were implemented with great success in our region this year.

We delivered four formal training sessions under the auspices of the deanery over the last year along with the local hospital based sessions. All these sessions were hands on where the learner had a chance to use the system with dummy passwords kindly provided by the ePF team. Another main advantage of this type of training was that, apart from learning how to manoeuvre through the software side of the system, other practical issues related to the use of e-portfolio in the anaesthetic workplace environment were highlighted and later on raised with the appropriate personnel.

We also suggest there should be e-portfolio local leads (trainees/trainers) at all hospitals who take an initiative in providing refresher sessions and help in sorting out simple problems and if required contact the College e-portfolio team or the deanery support officer.

**View from educational supervisors’ perspective**

The survey response from the educational supervisors and College tutors was approximately 70%. The response to the key question ‘ease of information collection for ESSR’ is displayed in Figure 4. It shows that 77.7% of the respondents found compiling the report either easier or no different compared to using paper versions of WpBAs and other evidence required for its completion.

**Figure 4 Ease of information collection for Educational Supervisor’s Structured Report**

<table>
<thead>
<tr>
<th>Easier</th>
<th>More difficult</th>
<th>Made no difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>48.1%</td>
<td>22.2%</td>
<td>29.6%</td>
</tr>
</tbody>
</table>

The freehand comments supplied by the supervisors were informative in suggesting areas where improvements might be made in the e-portfolio.

Comments included:

➤ Difficulty in finding the evidence within the portfolio to allow the sign off of a unit of training. This is related to the difficulty in assigning scanned paper assessments etc.

➤ Difficulties in navigating around the trainee records.

➤ Time consuming to have to open a large number of assessments to check which are relevant to the current unit of training being reviewed.

➤ MSF, once approved, disappears off the screen for a period of weeks.

➤ Supervisors felt they should be able to see who has responded and who is still to complete the MSF while it is in progress.

➤ The route within the portfolio to finding the Educational Supervisor Structured Report was not intuitive.

➤ Difficulties in reviewing evidence on the trainee’s portfolio while completing the ESSR. One suggested solution was to have two adjacent computers, one to view the evidence on the trainee’s portfolio while using the other to complete the report.

Since the survey, further modifications have been made to the ePF, as elucidated in the trainees’ section and from a recent communication by the ePF team at the College. These changes have addressed many of the above concerns.

The comments above were balanced by a large amount of positive feedback from the respondents.

**Conclusion**

The two key elements to the success of e-portfolio in our region were regular training sessions and good administrative support by the deanery specialty support officer. The dedication of local trainers and the enthusiasm of trainees to embrace this change made this rather challenging process turn into a smooth transition in our region.

The ePF is still evolving and, as with any new system, there will be teething problems. It takes a lot of time and resources to tweak any new system to perfection but this also needs the willingness of everyone involved to interact to make it successful. Many improvements have already been made since its inception and hopefully with continuing use and regular feedback more changes will happen to make it easier to use.

We have now conducted three e-ARCPs in the region and are in a position to believe that it is time to embrace change and move onto an electronic system.
Establishing a mentoring and coaching programme
An interview with Dr J Ropner

What is a mentor?
A mentor is usually a more experienced person who shares knowledge with their mentee, supporting them, encouraging them and challenging them so that they can deal with difficulties, learn more about the organisation in which they work, and about themselves. It is a confidential relationship, which may be long term, and the agenda is set by the mentee.

How long has the mentoring programme been established?
Gloucestershire Hospitals have had a mentoring programme since 2002 when Gloucestershire Royal Trust and East Gloucestershire Trust merged into the Gloucestershire Hospitals NHS Trust.

What were the drivers for development of the programme?
It was perceived that consultants were taking up their posts earlier as periods of training reduced. They had the clinical skills to do their jobs but as they were younger their life skills were less developed. It was also seen as a way of showing that we valued this group of staff.

How does it work?
One of the associate medical directors (AMDs) actively manages the programme. The mentoring programme is mentioned in the job description for new consultant posts. Medical staffing regularly inform the AMD of the names of recent appointments and mentors are asked if they have availability to take on a new mentee. Mentees are matched with a mentor, usually from a different discipline. This is because experience has shown that if colleagues have problems they are usually related to interpersonal problems or dysfunctional teams. As mentoring is a generic skill there is in theory no reason why the relationships will not work, but if people are not comfortable with their mentor they can request another.

All consultants appointed since 2002 have been offered mentors. Not all took up the offer. In addition, all existing consultants were offered a mentor at one time but only two people responded positively. The programme was initially for consultants but we are now expanding it to include SAS doctors.

More doctors are now being referred to the GMC by patients. The first they hear of this is when they receive a letter from the GMC to this effect. The Medical Director receives a letter at the same time so we write to anyone referred to the GMC offering mentoring support, as this can be very stressful for the doctor. Mentoring is also offered to anyone under investigation because their performance has given rise to concern or it may be included as part of a remediation package.

Initially, mentors were recommended by their clinical directors. Those who were interested were trained. Most of them were already carrying out appraisals for their junior doctors and had been trained for this. There is some overlap between appraisal and mentoring training, for example the ability to listen actively and to ask open questions. Mentors need to be interested in people and to have time to take on this role.

More recently we have asked for volunteers who have gone through an interview process with one of the non-executive directors as chair of the panel. There are now some SAS doctors amongst the mentors.

What training do mentors have?
An external company was brought in to train the first group of mentors.

Since then training has been provided by the Leadership and Development Department who have provided training elsewhere in this field. The training includes role play. Once they are trained they can start mentoring and we hold two support groups annually where they meet.
together to share interesting experiences and additional training is provided. For example we recently had a session on the use of coaching questions.

**What ongoing support is available for mentors?**
Biannual support groups are held but mentors can also use buddies within the group or discuss things confidentially with the AMD who runs the programme.

**What have been the challenges of setting up the programme?**
When it was set up it was not taken seriously by all colleagues. There was confusion with counselling and there was a perception that it was a weakness to need any sort of support.

Clinical directors have asked for details of their colleagues’ mentors to try and elicit support to deal with difficult problems. It has to be pointed out that these relationships are confidential and they can only get that information if the mentee wants to provide it.

Mentors have had difficulties in knowing where to refer colleagues when there are issues that they cannot deal with. This has been discussed at a support group.

How the scheme can be evaluated is a major challenge.

**Feedback**
Some years ago we sent out a questionnaire to all mentors and mentees.

- 82% of mentors responded and reported that the most common problem experienced was difficult relationships with colleagues. As these are newly appointed senior doctors this is a concern.

- 50% of mentees responded. 12 out of 13 had met with their mentor; the frequency of the meetings ranged from once only to every few weeks for two years.

- The relationship was described as better than expected by one person, eight people found it as they had expected and four had no expectations.

Now the challenge is to try and test whether it gives value for money. We know that we do not lose newly appointed consultants in the first few years in the same way as some Trusts report, but cannot prove that this is anything to do with the mentoring we offer.

**Example one**

An example of the benefits of mentoring:

We have one example of somebody who was appointed as a consultant after working in the trust as a trainee. Quite quickly she perceived that she changed from being seen as a hard working valued registrar to a ‘pain’ in the eyes of her colleagues. She required intensive support, needing to see her mentor weekly on a Monday morning for eight weeks to enable her to come to work at all. She felt that she was being bullied and came close to being unable to work. One day her mentor asked her whether she thought she could have responded differently to a difficult situation; after a period of silence she said that she could see that her colleagues would not change so if she was going to survive she had to change. She was able to do that and life became more tolerable.

**What tangible benefits have you seen from the scheme?**
On one occasion, that we are aware of, mentoring has made the difference between continuing at work or potentially resigning from the post (see example one). Two cases have been documented of colleagues who met once with their mentors and felt they did not need to continue the relationship. In both cases a year or so later problems were encountered and they both asked to see their mentor again who was able to help them. This is very encouraging.

**What is meant by coaching?**
Coaching is a powerful tool used to develop people. The coaching relationship is usually shorter than a mentoring relationship; meetings are scheduled regularly and focus on a particular development need, the agenda being dictated by the coachee (see example two).

**Who is qualified to coach?**
We have a group of senior staff who are qualified executive coaches (ILM Level 7 Certificate in Executive Coaching and Leadership Mentoring). We are trying to introduce a coaching culture into the organisation. Hopefully this will gradually happen.

**How do coaching and mentoring interact?**
There is some degree of overlap between mentoring and coaching, and it may be that during a coaching session some mentoring is added if it seems a valuable thing to do. Some colleagues have both a mentor and coach.

**What is the relationship between appraisal and mentoring?**
Appraisal is essential for revalidation. It cannot be replaced with anything. It happens once a year. Mentoring runs in parallel, can occur throughout the year and can be used to support individuals who are having difficulties with job planning, workload issues or any aspect of their appraisal but not to solve these issues per se. They are very different but the appraiser may use mentoring techniques and questions.

**Are these programmes readily transferred to other hospitals?**
Absolutely. In fact the Royal College of Physicians has realised the benefits of mentorship and is recommending it for all physicians. I informed them...
about our programme and I have now been nominated to provide advice for those setting up schemes. I have written some guidance which has been sent out to those requesting support.

Similarly for coaching, but it is important that coaches have recognised qualifications.

**How satisfied have you been personally with the introduction of mentoring?**

I am very pleased with the mentoring programme. I see the difficulties faced by my younger colleagues and I am pleased that we have the resources to offer support. It is particularly pleasing to see male colleagues return to their mentor after a considerable time asking for help with a problem.

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### Example two

**An example of the benefits of coaching:**

A nurse is promoted to a post three grades up from his current post. This is an educational post and he can cope with the bread and butter, but finds it difficult to relate to his new peers and does not have any confidence to speak in meetings.

So he is given a coach. They agree to meet on four occasions to start with. To prepare for the coaching he must think of a problem area that he finds difficult. He is asked what outcome he wants from the session.

He explains the problem to his coach who gleans more information by asking questions. By asking open questions and getting him to reflect on things, and also by the use of silence, the coach tries to get him to produce his own solution or a set of options.

Once he has worked out how he is going to do whatever it is by responding to questions and thinking, he is then asked how likely he is to do that on a scale of 1–10. If the answer is low they look at why that might be.

If he had gone on a course he would not have had 1:1 attention, unless the course offered coaching and even if he could have discussed his own problem people might have been tempted to advise him. If you work out how to sort out your own problems you are much more likely to be successful.

In coaching you focus on specific developmental areas or goals and it is a powerful developmental tool.
Thinking inside the box – cloud computing

We are often applauded for ‘thinking outside the box’, developing new and novel approaches to problems. While this is an important skill, sometimes it would be helpful to remember the details of a tried and tested solution to a clinical question. If only we could remember what was inside the box in the first place.

This article will explain how one hospital has begun using cloud computing technology to overcome a range of old and new problems.

‘Cloud computing’ is a term used to describe a system where software is stored on various servers rather than clients’ own computers or hardware. It enables rapid distribution of media and can aid departmental function. The development of several user-friendly companies who provide smartphone applications and web pages has revolutionised the potential of this market.

Online cloud storage companies include Box, Dropbox, Apple’s iCloud and ownCloud. They all offer file sharing software, using the concept of cloud storage to remotely store and distribute files amongst individuals, but all with a variety of benefits and drawbacks.

This article will focus on ‘Box.com’, the program used by the anaesthetic department at Hillingdon Hospital to create the ‘Hillingdon Cloud’. The service can be accessed via standard desktop computers and has applications for smartphones and tablet PCs. It allows users 24-hour access to stored files, from any device where the application and internet access are available (Figure 1).

A recent survey, published in Anaesthesia, highlights the already widespread use of iPhones for medical applications amongst UK anaesthetists and cloud storage is ideally placed to utilise this resource.¹

Put your head in the clouds!

Why is cloud computing important to anaesthesia?

Over the last decade, the government made a large financial investment in the National Program for Information Technology (NPfIT).

Launched in June 2000, the NPfIT aimed to improve standards in NHS information technology and had four key goals: the Choose and Book system, national electronic health records, e-prescriptions and a new broadband infrastructure. Whilst the broadband infrastructure has been realised, although over budget, the other components have been less successfully implemented. With funding for this project largely withdrawn and minimal improvements seen at local levels, it has fallen on individual hospitals and departments to find solutions for their needs.

Management leaders put huge weight behind keeping their team up-to-date with new information, evidence and guidelines. This is true in business and increasingly true in clinical management. However, being presented with all this information at once, such as at hospital induction, can lead to important documents being ignored or diluted by the quantity of information being offered. Allowing individuals to access this information at their leisure, and review it again on-demand and at the point of use, bypasses these problems.

Figure 1 The Box.com scrolling menu displaying the indexed CATS emergency treatment guidelines on the iPhone.
Clouding our judgement

How are we using the Hillingdon Cloud in our daily practice?
The following list details files made available at Hillingdon Hospital and some of the potential benefits:

- Departmental contact details – staff are always able to access help.
- Weekly theatre rota – instantly updatable and may reduce the requirement for expensive rota management software.
- SpR and SHO rota – trainees can be given access to this prior to their arrival and choose a rota slot.
- Local departmental guidelines (e.g. acute pain, rapid recovery programmes etc) extremely helpful for trainees changing hospital frequently.
- Journal club and in-hospital audit/teaching presentations – allows easy distribution of journal club and no need to have an iron-key to upload presentations via USB.
- Guidelines
  - Emergency treatment guidelines (e.g. CATS/AAGBI/DAS [Figure 2])
  - NICE/RCoA
  - Patient information leaflets (e.g. OAA epidural language sheets).
- Pastoral documents – trainee curriculums, workplace based assessments, competency documents. Annual and study leave application forms and guidance (all of which can be accessed and printed by users at home).

From our experience of using the Hillingdon Cloud, we have found that a departmental account offers clinicians real-time, bedside access to treatment guidelines, offering patients access to the most recent evidence-based care. With this access being delivered to smartphones, it can, for example, allow the dilution of a particular infusion to be calculated, without having to leave a critically ill patient to go and find a desktop computer.

A European Working Time Directive shift system means that it can be difficult for trainees to attend all teaching sessions. By uploading presentations to a cloud storage system trainees can access teaching sessions they were unable to attend or view journal articles prior to journal club, to ensure full coverage of the curriculum.

It provides the opportunity for trainees to be given the responsibility of updating specific documents or folders. For example, a trainee doing an intensive care module could be asked to perform a literature search on renal replacement therapy and write a document referencing the latest articles. This provides a useful step for senior registrars between following and writing guidelines.

In theory, any file can be stored and distributed via cloud storage. The common ground between different anaesthetic departments means that a number of similar uses may be found between different hospitals.

Every cloud has a silver lining

Why choose a cloud storage solution over another file sharing system?
The same data that can be stored in a cloud storage system can be stored on a website or intranet, but we believe a number of key features of cloud storage systems offer an advantage over these older technologies.

Dropbox and Box services both have official apps featuring rapid search functions and access to all folders.

It is simpler to manage the files with a cloud storage system. Within the Hillingdon Cloud, all individuals have the ability to upload files, following approval from the department administrator. Uploading can be achieved via the service web portal or sent as an email attachment to the folder. Passwords or open access to the public are unnecessary as the administrator only grants access to relevant parties.

In the Hillingdon Cloud, files viewed and stored by a user as a favourite can be accessed offline, giving access to treatment guidelines without internet availability. This is invaluable as many hospital departments have a very poor signal due to their location.

Most file-sharing systems can be joined for free and set up in the same way that an email account can be created online. Thus, the system has low running costs and avoids the need to purchase or maintain expensive hardware or web domains.
Cloud storage systems can be set up to send email updates when new information and files are added, keeping users updated. This can become overwhelming but within the Hillingdon Cloud this is straightforward to control. Comments and tasks can be assigned to files and real-time updates allow two people to work on the same project.

Storm clouds looming
Potential drawbacks of a cloud storage system
The creators of several cloud storage systems describe them as safe storage facilities; however, not all systems can store or send encrypted information. Therefore, in keeping with the Caldicott principles and local confidentiality policies, cloud storage services should not be used to send or store patient specific data. At this time the authors are not aware of a way for healthcare professionals to share sensitive patient data outside an nhs.net to nhs.net email exchange.

Under a cloud of controversy
What do the Hillingdon Cloud users think?
We surveyed 49 current Hillingdon Cloud users. Of these 31 (63%) responded and provided us with illuminating data. 83% of users would prefer to use the Hillingdon Cloud compared to the hospital intranet. Furthermore, an overwhelming 93% of users rated the Hillingdon Cloud as very or often useful (based on a 4-point grading scale with very and often representing the top two responses).

Table 1 highlights the resources users felt they accessed most frequently.

<table>
<thead>
<tr>
<th>Which of the following do you frequently access via the Hillingdon Cloud?</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local guidelines</td>
<td>79</td>
</tr>
<tr>
<td>National guidelines</td>
<td>72</td>
</tr>
<tr>
<td>Rota</td>
<td>62</td>
</tr>
<tr>
<td>Departmental teaching</td>
<td>58</td>
</tr>
<tr>
<td>Emergency treatment guidelines</td>
<td>55</td>
</tr>
<tr>
<td>Pastoral documents (WpBAs)</td>
<td>20</td>
</tr>
<tr>
<td>Patient information leaflets</td>
<td>17</td>
</tr>
</tbody>
</table>

Box.com also provides useful information on the number of downloads, 50 file previews and 11 uploads. Evidence that users are engaging with the Hillingdon Cloud.

Clouds on the horizon
Future developments
Whilst at the moment we know of individuals and departments with cloud storage accounts, it would seem likely that schools of anaesthesia and possibly royal colleges could benefit from distributing information in this manner.

On cloud nine
Conclusions
We believe that cloud storage devices offer doctors and anaesthetic departments a cheap, simple and effective method for sharing clinical and administrative information. Many users in our department prefer the Hillingdon Cloud to the hospital intranet to access the same information. The ability of users to submit their own files enables greater engagement from staff and more efficient use of administrative resources. Moreover, it delivers information to the bedside and therefore enables us to expedite patient care.

Permissions
Permission was gained from the Children’s Acute Transport Service (CATS) to utilise images of their guidelines in this article.

Reference
Too much information

In my role as Media Advisor I am a political neutral, but I suspect that like a lot of people who are watching unfolding events with a critical eye surrounding the debate about NHS reform, I feel that I am drowning in too much information.

There has been an unprecedented release of surveys, analysis and recommendations over the last few months, all related to the proposed NHS reforms.

*The Times* reported that following Jeremy Hunt’s appointment as the new Health Minister, several members of the Cabinet gave a collective sigh of relief. They saw ‘the job of implementing unpopular and complicated reforms, in an NHS squeezed by the demands of austerity, aging and obesity, as potentially career-wrecking.’

The same article also noted that ‘…waiting times are the main way in which the media and the public judge the NHS, and that the target of treatment of a maximum wait of 18 weeks was a crude benchmark, but one that is more intelligible than anything the previous Health Minister, Andrew Lansley, ever said.’

As an example of where we are, the ‘avalanche of surgical demand’ predicted in *The Financial Times* seems to be mirrored by a similar ‘avalanche of information’ being released.

Opinion polls and surveys are always a popular method of reporting and reflecting the mood of the nation, although there is a lot dependent on the way a single survey question is phrased.

Surveys can always be relied on to produce some shock statistics, preferably buried towards the end for maximum effect, such as a BBC survey which reported that:

*Nearly 75% of those questioned did not trust the government.*

So how does a news or media organisation such as the BBC actually cope with reporting such an unprecedented quantity of material, let alone analyse it?

I asked Branwen Jeffreys, BBC News Chief Health Correspondent, to explain:

**Has there always been a Health Unit within BBC News? Or is this a more recent innovation?**

The BBC is very committed to having specialist journalists working within national news, so certainly for my entire working life there have been Health Correspondents. Some years ago health, science and environment journalists were brought together into one large extended team reporting for national news. There are similar specialist units for business and economics, home affairs, social policy and education etc. It’s a system designed to allow journalists to develop a greater breadth and depth of knowledge. That really helps when there is a complex breaking story as we have background knowledge and the contacts to make rapid checks and provide context.

People expect BBC news to have accuracy and authority.

**How many correspondents are there and do they report for every part of BBC national news?**

At any one time we have around five or six Health Correspondents who are reporting for BBC news nationally. We work together as quite a closely knit team alongside other experienced journalists who help support our work. Not everyone wants to broadcast, some journalists prefer to mainly just write for the website or to research and arrange the logistics of telling a story for broadcast. Each of the correspondents tends to concentrate on one medium, in my case that’s currently TV, but we all work very flexibly. So I also sometimes write for the website and broadcast on our various radio
Health stories have to compete for inclusion in the various news programmes with the full range of national and international affairs. The most fascinating health story of the year could still barely get a mention if it fell on a day when something else extraordinary was happening at home or abroad.

Would you agree that the very nature of the way the NHS is regarded by the public, government and those who work within it, makes it one of the most politically delicate areas of public life that the BBC has to report on? Is the obligation to be balanced ever difficult?

Not all our stories are of a political nature but of course the NHS has a particular place in national life. It accounts for one of the largest slices of public spending and millions of people use the services each day. Many people have views on it, often very passionately held and argued! At the moment there is quite an intense debate about the changes to the health service in England. We have to stand outside that and report it as it unfolds. Balance in this context is an important duty we take seriously not an onerous obligation. More generally, I chose to work for the BBC because I want to work in an organisation where there is a strong ethical context for our work. Sometimes there are facts which are uncomfortable for both, or several, sides of a debate. It is more common that there are many perspectives on a subject than a neat divide into opposing views. Where you stand on an ethical decision can be intensely personal, with lots of views that are varying shades of grey.

What makes a good story for you and what kind of audience response do you get? Are you closely followed?

The starting point is usually a series of questions – how new is this, how many people are affected, how controversial is this issue, what is happening that means we should report it now? To make a strong story into a piece of engaging TV is sometimes a logistical challenge. Sometimes it is the compelling account of a patient or doctor that we know will draw our audience in to listening and watching more carefully.
Where there are complex ethical issues we think carefully about the weight we give in terms of time and impact to different points of view. Once we have got the facts straight, a great deal of thought often goes into how we tell the story to make it clear. Across the various news programmes the BBC audience includes everyone from people working on supermarket check outs, on building sites to chief executives of large companies and university academics. We want our coverage to be intelligent and informed, but also clear.

One thing really has changed in my working life; we have a more direct connection to our many audiences than ever before. The web and email have made it very easy for people to get in touch about our stories, posting comments for example on the BBC news website. Sometimes that uncovers extraordinary personal stories which we follow up. This year I've got involved with Twitter as @branwenjeffreys which is becoming another useful way of reporting, telling people what we are doing, and listening to debates between academics, campaigners and individuals.

Sum up for us what your job means to you. Where does the satisfaction come from?

My job is endlessly varied and unpredictable. That can be exasperating when I get called late at night as a story breaks, or get up at the crack of dawn to broadcast in my dressing gown on the Today programme from my study, or travel to the other end of the UK to film. The reward is in the constant intellectual challenge and the many interesting people I have the privilege to meet and interview. I have to be able to digest a 40 page closely argued judgement from a High Court judge, follow the shifting sands of a political debate, know where to find information and how to analyse it, and still to be able to sit down in the front room of someone who is very ill or frail and make it possible for them to tell me their story without being distracted or overwhelmed by the presence of a TV camera. I feel very lucky.

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I was lucky enough to be invited to the opening of the Science Museum’s new exhibition ‘Pain Less’. The RCoA and the AAGBI are major sponsors of this exhibition that has evolved from a concept encompassing the broad themes of anaesthesia, consciousness and pain. It has been developed through consultation with experts in the fields of anaesthesia and pain research, chronic pain sufferers, and schoolchildren. It focuses on the interaction of the mind and body in the experience of pain, the innovative research that is underway to develop drugs and technologies to treat pain, and the experience of people living with chronic pain.

There are four major sections, each with a short film, all of which have an individual’s story at their centre, either someone living with chronic pain, or involved with pain research, or both.

Melvin is a medical student who has taken time out of his training to complete a neurosciences PhD. He is participating in research into the effect of expectation and mood on pain. He is subjected to painful stimuli whilst listening to music designed to induce emotions such as sadness. He undergoes brain fMRI at the same time to demonstrate the influence of emotion on the processing of painful stimuli.

I also met Peter, who has suffered with phantom pain for more than 20 years. He is trialling novel technology designed by the University of Manchester that utilises virtual reality to help people with phantom limb pain. He enters a virtual reality environment where he is performing tasks with his amputated arm. This gives him enormous benefit, with his pain becoming almost non-existent for up to two days afterwards.

The relationship between consciousness and pain is explored with an elegant demonstration of a patient undergoing a procedure under sedation. She is able to obey commands and feel pain, yet has no recollection. The question is asked, ‘do we feel pain under anaesthesia and if we do does it matter?’ In addition to bispectral index the exhibition introduces the fEITER (functional electrical impedance tomography of evoked responses) monitor. This device measures electrical impedance to construct a cross sectional image of electrical conductivity within the brain. The response speed is rapid and so it could potentially be used to monitor the response of different parts of the brain to anaesthetic drugs in real time.

The most fascinating part of the exhibition for me was the live demonstration of tarantula milking! With the discovery of a loss of function mutation in the SCN 9A gene that encodes for the Nav 1.7 sodium channel in individuals congenitally insensible to pain the search is underway for naturally occurring chemicals that could be used to block these channels. Steven Trim is the director of Venomtech, a company specialising in the provision of snake and invertebrate venom. He has combined his experience in pharmaceuticals and pain research with his hobby of keeping snakes and tarantulas. We took our positions at a safe distance while the tarantula was gassed down in carbon dioxide enriched air. It was then extracted from its box and electrodes were placed on its head to stimulate muscle contraction and hence venom release. Tarantulas can remain sedated for up to an hour using this technique and can undergo venom extraction up to once a fortnight.

This exhibition is great for the profile of anaesthesia, and in particular pain medicine. It sheds light on some of the areas that anaesthetists work in, along with the latest research, and will hopefully give the public more of an idea about what an anaesthetist does!

Find out more about the exhibition at www.rcoa.ac.uk/painless

Image: Tarantula venom extraction (reproduced with permission from the Press Association)
Dear Editor,

Auxiliary common gas outlet

Having read about the patient safety incident involving a GE Aespire anaesthetic workstation in the Patient Safety Update (September Bulletin) we would like to highlight what we feel is an important additional patient safety issue relating to the Aespire anaesthetic workstations manufactured by GE Healthcare. In 2009 we purchased 13 Aespire workstations. All of our consultant and trainee anaesthetists, and the operating department practitioners (ODPs) underwent training provided by GE Healthcare. Our lead ODP attended a 'train the trainers course' specifically for use of this machine. Despite the above we have repeatedly encountered a specific problem involving the anaesthetist inadvertently using an incorrect setting of the auxiliary common gas outlet (ACGO) switch. This has resulted in a failure to deliver the selected anaesthetic gas mixture and on one occasion caused profound hypoxia. We informed both GE Healthcare and the Medicines and Healthcare products Regulatory Agency (MHRA) of these events. Further training was offered and delivered by GE Healthcare. We suggested that the manufacturer provide a software modification so that a large visual alert appears on the ventilator screen when switching to the ACGO. However, this was deemed undeliverable.

We also contacted the MHRA during this time, who concluded that no fault could be attributed to the manufacturer and that the cause of the problem was 'user error'.

This problem has persisted despite ongoing training and awareness raising amongst anaesthetists of all grades in our department. Further contact with both GE Healthcare and MRHA produced no response, although we note an MHRA Alert (December 2011) regarding this very problem. We therefore assume this potentially catastrophic event is happening in hospitals other than our own.

It is our view that the design of an anaesthetic machine should be such that an adequately trained anaesthetist finds it very difficult to use the machine incorrectly. This is especially important in the modern NHS where hospitals have a high turnover of trainee and locum staff. The fact that an MHRA alert has been issued suggests it is not just ourselves who are having problems related to the design of the machine. Thus it cannot simply be attributed to user error. We feel that it is more likely to be the design of the machine itself which is contributing to these patient safety incidents, and that manufacturers have a duty to upgrade machines in use to make them as safe as possible where design faults are identified.

Dr J Stone
Dr C Frerk
Dr N Robinson
Dr K Leyden
Dr D Jolliffe
Dr R Webster
Dr C Leng
Dr P Davies
Dr M Nwe
Dr S Kumaran
Dr P Jameson
Dr P Bheemappa
Dr J Wilkinson
Dr M Outram
Dr J Hare
Dr J Hardwick
Dr A Dash
Dr P Slater

Consultant Anaesthetists
Northampton General Hospital

References


Dear Editor,

Thank you for allowing GE Healthcare a right of reply about the auxiliary common gas outlet (ACGO).

The auxiliary common gas outlet is an option on all GE Healthcare anaesthetic machines. The ACGO gives anaesthetists the flexibility to use additional breathing circuits for particular patient types or specific clinical procedures. The majority of anaesthesia machines sold in the UK have the ACGO option to offer this user flexibility. The ACGO outlet and its activation conform to all UK and international regulatory standards.

GE Healthcare fully investigated the correspondents, ACGO product complaint in conjunction with the MHRA. Ultimately, the report highlighted a user error, which was agreed at the time by the hospital, MHRA and GE Healthcare. The anaesthetic, theatre and technical staff were also visited on a number of occasions by GE Healthcare’s UK service, sales, product management and academy staff. The ACGO activation performed as it should and as highlighted in the user’s operation manual. The activation of the ACGO on the Aespire gives the user a number of visual warnings to highlight the ACGO has been activated.

➤ A Bain type circuit is placed in the top right hand corner of the ventilator screen.
➤ An auxiliary common gas outlet is on message is placed across the centre of the ventilation waveform field informing the user the ACGO has been activated.
➤ Finally, the user is alerted that the ventilator has been disabled in the alarm section of the ventilator screen.

A suggestion by the anaesthetic department at the correspondents’ hospital to improve the ACGO visual indication had been activated on the ventilator screen was made. This suggested improvement was to make the font size larger; however, during these discussions, the users indicated their back was to the machine as they would be treating the patient and that they did not always look at the ventilator screen. In GE Healthcare’s considered opinion increasing the font size would not stop this event from re-occurring, if the user did not look closely at the screen.

GE Healthcare has been working with the AAGBI and MHRA on improving anaesthesia safety and reducing anaesthesia equipment risks. During February 2012 GE Healthcare arranged for Mr Matti Lehtonen, the Global General Manager for GE Healthcare’s Anaesthesia Division to visit a number of sites in the UK. This was to gain further insight into the UK Anaesthesia clinical practice and to understand further the different needs of particular patient groups, for anaesthetists when using GE Healthcare anaesthesia machines specifically related to the use of the ACGO. Mr Lehtonen met a number of senior and well respected consultant anaesthetists and he has indicated he will look at the current design set up of the ACGO.

A report of GE Healthcare’s recent activity on the auxiliary common gas outlet question was presented in July 2012 to the AAGBI/Barema meeting held in Portland Place. The SALG representative was present at this meeting.

In closing, Mr Lehtonen has indicated GE Healthcare would look at the current ACGO design and its compliance to current international safety standards, future international standards and future anaesthesia trends with regard to GE anaesthesia machines.

David Walker
Anaesthesia Product Manager UK and Ireland
The chairman then introduced the guest speaker Mr Edmund Conway, currently the economics editor of Sky News and former economics editor of the Daily Telegraph. Mr Conway is the son of the late Cyril Conway who was Professor of anaesthetics at Westminster Hospital Medical School and a member of College Council. The title of his talk was 'The Tale of Two Unions: the US and Europe in 2012 and Beyond’. The nub of his presentation was how fiscal union works or could work in the USA and Europe. He started his presentation by showing how the public culture and mood has changed in the USA as was seen in the recent negative presidential election campaigns and as Americans perceive that the USA could be overtaken by China as an economic superpower by the end of this decade. Fiscal union in the USA happened after the Civil War; the debt was mutualised and fiscal union was a gradual process over many years.

For fiscal union to work there must first be monetary or currency union and then an agreement that the richer states, regions and or countries subsidize the poorer ones, that is, a redistribution of wealth. Signs that monetary union is working are similar cost of borrowing for regions or countries, similar cost of borrowing for consumers and convergence in unit labour costs (efficiency). This is seen to work in the USA and also the UK.

The picture is different in the euro zone. One of the main reasons for the euro crisis is that the unit labour costs (inefficiency levels) vary between the euro countries. The cost of borrowing also varies. Mr Conway showed a slide of the cost of buying a glass of beer in Europe which illustrated these differences simply and clearly. In other words, in more efficient countries (for example, Germany and France) one euro buys you more than in less efficient countries (for example Greece and Italy). Effectively it is not one currency.

There are several ways out of the euro crisis but not one or all are acceptable to any one country: devaluation, austerity, allowing inflation to rise and a permanent transfer of money from richer to poorer countries. The differences in culture, expectations and historical perspectives make it difficult for pronouncements from Brussels to be implemented in individual countries. What started out with good intentions after the most bellicose period in European history now appears to be stalling.

The chairman thanked Mr Conway for an illuminating and interesting exposition on a difficult subject.

Date of next meeting

The next meeting of the Senior Fellows Club will be held at the Royal College of Anaesthetists in London on Thursday, May 23 2013 when the speaker will be Dr John Meadley MBE on the subject of overseas aid.
As We Were

That the application of Electricity during the extraction of a tooth will produce local anaesthesia, is a fact which, during the last sixteen years, I have had opportunities of verifying many thousands of times, as scarcely a day has passed without my having several operations. When in 1858 the results of my first experiments were published the subject excited intense and general interest, which a few in the profession still feel, and who continue the use of the electrical anaesthetic with success to themselves and comfort to their patients. By the majority, however, it has been abandoned, chiefly on account of... the want of manageable electrical machines, forceps properly insulated, and other minutiae necessary to success, which time, attention, and perseverance alone can develop.

...I consider this case worthy of record. The gentleman, a foreigner, called upon me late one afternoon to have a tooth extracted under the influence of chloroform or gas. Informing him it was not safe to use either of those agents without the assistance of a practitioner who was accustomed to their administration, and as he wished it done that afternoon it would be dark before one could be procured; further, that it was not advisable to operate by artificial light, I suggested that without any assistance he might have the tooth safely and painlessly removed through the agency of Electricity. This he had never heard of as being so employed, and the recollection of the excruciating suffering he had endured during a former extraction made him tremble with apprehension: consequently it was only after hesitating a considerable time and remembering that he had to commence a long voyage on the following day, that he took courage from what I said and submitted to the ordeal. The tooth was a right upper molar, much decayed, and broke during the extraction, one fang being left in its socket. With his tongue he felt this and requested me to remove it, which I did, and needless to say this gave electricity a very severe test, yet after the operation he expressed himself delighted with the result. The next day he had to sail for South America, where he said he hoped they could operate in the same manner. On giving him two copies of my pamphlet I told him it was probable that any practitioner, feeling an interest in the subject, would therein find ample directions to enable him to perform a similar operation.

The next morning brought this letter from him: Dear Sir, Having perused your book on Electro-Dentistry, and the ten cases described, I must say that none of them expresses the feelings of the patient in such a way as to give confidence to a patient who might be afraid of undergoing the operation. I therefore wish to express my feelings in the case, perhaps for the benefit of some of your patients, who like me, might be afraid of undergoing the operation.

When the beaks of your forceps entered between the gum and the tooth, I felt a sensation in the gum the same as I should feel in the hands touching the handles of an electric battery, such as shown in fairs; the action of drawing the tooth I did not feel, either pleasantly or unpleasantly... Thankful to you for your kindness both before and during the operation, if operation it can be called. I remain yours most obediently,

T. SPRINGLE, Washington Hotel, August 26, 1873.

*********

From: Electro-dentistry – facts and observations, by Joseph Snape, LDS RCS. Simpson, Marshall, and Co. Liverpool, 3rd Edition. Snape was Dental Surgeon to the Liverpool Royal Infirmary, and Lecturer in Dentistry at its Medical School.

He described a number of successful cases, including a member of the medical staff. He found that success depended on so insulating the forceps that the electrical current passed only through the tooth, not the gum. This was supported by an editorial in the American Journal of Dental Science – ‘When the tooth can be grasped and extracted without the instrument coming into contact with the gum, the operation has been completely successful...’ The main problems, leading to inconsistency of results, were difficulty with the insulation of the forceps, and with the electrical machine.

With the benefit of modern manufacturing technology dental electro-anaesthesia has been re-introduced in the United States, and is being practised with almost complete success in some centres, according to articles on the web.

David Zuck
History of Anaesthesia Society
Report of Council

At a meeting of Council on Wednesday, 17 October 2012, the following appointments/re-appointments were approved (re-appointments marked with an asterisk):

Regional Adviser
Northern Region
Dr G R Enever in succession to Dr Karen Beacham

Deputy Regional Advisers
There were no appointments or re-appointments for Council to consider.

College Tutors
North Thames West
Dr N Barker (Chelsea and Westminster Hospital) in succession to Dr P B Brooks

North West
Dr C Coldwell (Lancaster Royal Infirmary) in succession to Dr S Richmond
*Dr D A Watson (East Lancashire NHS Trust)
*Dr S Mirza (Royal Oldham Hospital)

North of Scotland
To receive a request from Dr J Read, Regional Adviser, for an extra tutor at Aberdeen Royal Infirmary

West of Scotland
Dr K R Fitzpatrick (Institute of Neurological Sciences, Southern General Hospital) in succession to Dr L B Stewart

Wessex
Dr P Mackie (Southampton University Hospital) in succession to Dr R Heames

South Thames West
Dr S Bailey (Epsom and St Helier Hospital) in succession to Dr M Hendricks (Acting Tutor)
*Dr K S Paramesh (Kingston Hospital)

South Thames East
*Dr S A Leonard (King’s College Hospital)

Sheffield and North Trent
Dr T Meekings (Chesterfield Royal Infirmary) in succession to Dr S Capper
Dr K U Farooq (Doncaster and Bassetlaw Trust) in succession to Dr J Allen

Wales
Dr T Sheraton (Royal Gwent Hospital) in succession to Dr S Sindhakar

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 Intensive Care Medicine.

September 2012

London
Dr Mark Snazelle *
Dr Constandinos Papageorgiou
Dr Rosemary Tallach
Dr Serena Bourke
Dr Vinita Felmine

East Midlands
Dr Victoria Banks *

Mersey
Dr Catherine Gerrad
Dr Eoin Young *

Northern Ireland
Dr Paraskevi Koutsoumpi
Dr Laure Martin

North West
Dr Thomas Varghese

Oxford
Dr Andrew Johnson
Dr Nawal Bahal
Dr Paul Greig

Scotland
Dr Murray Blackstock *
Dr Rosaleen Macfadyen *
Dr Kristina High

Severn/Bristol
Dr Lucy Kirkham
Dr Dominic Hurford
Dr Miguel Ernesto Garcia Rodriguez *

South West Peninsula
Dr Nigel Hollister *
Dr Claire Preedy
Dr Richard Kaye

Wessex
Dr Shiny Shankar

Yorkshire
Dr Paresh Rajendran
Dr Deedy Elmissiry
Dr Ravindranath Parekodi
Dr Gowri Subash
Dr Anna Girolami

* Joint CCTs in Anaesthetics and ICM

ERRATUM TO NOVEMBER ISSUE
Regrettably a spelling error was made in this list in our November issue.
The correction is:

London
Dr Louise McWhirter*

ELECTION
Northern Ireland Advisory Board 2013

IMPORTANT NOTICE
Please refer to the College website for details of the election to the RCoA Northern Ireland Advisory Board in 2013. The ballot count will be held on Wednesday, 20 February 2013.

www.rcoa.ac.uk/northernireland
Appointment of Members, Associate Members and Associate Fellows

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

**Associate Fellows**
- Dr B K John
- Dr H E Bunting
- Dr M S Shekar
- Dr J P Johnston

**Member**
- Dr M A Khan
- Dr S Vijayarajan

**Associate Members**
- Dr M Jaworska-Grajek
- Dr L F Hughes
- Dr P Kontina
- Dr P Verma
- Dr L Prisco

**Affiliate – Physician’s Assistant**
- Mr M D Wragg

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Appointment of Fellows to consultant and similar posts

The College congratulates the following Fellows on their consultant appointments:

- Dr E Balakumar, Hull Royal Infirmary
- Dr P Balasubramanian, Hull and East Yorkshire Hospitals NHS Trust
- Dr J C Bolten, St George’s Hospital
- Dr S Cook, Royal Gwent Hospital, Aneurin Bevan Health Board
- Dr Ed Copley, Kettering General Hospital
- Dr A D Drummond, Pennine Acute Hospitals
- Dr C L Eckersley, Crosshouse Hospital, Kilmarnock
- Dr D Felstead, Chelsea and Westminster Hospital
- Dr S Jagannathan, University Hospital Birmingham
- Dr V K Jagannathan, University Hospital of North Tees, Stockton on Tees
- Dr R Macfadyen, Western General in Edinburgh
- Dr O Mateszko, Sheffield Teaching Hospitals NHS Foundation Trust
- Dr T McCarthy, Milton Keynes Hospital NHS Trust
- Dr F Mir, Royal National Throat, Nose and Ear Hospital, London (LOCUM)
- Dr U A M Puar, University Hospital of North Staffordshire
- Dr A R Satapathy, Edinburgh Royal Infirmary
- Dr C Sheehan, Chelsea and Westminster Hospital
- Dr S B Tatikola, Hull and East Yorkshire Hospitals NHS Trust
- Dr R D Tipping, Queen Elizabeth Hospital, Birmingham
- Dr L Waddilove, Freeman Hospital, Newcastle

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Deaths

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

- Dr H G Balmer, Devon
- Dr W J Colbeck, Doncaster
- Dr H M C Corfield, Somerset
- Dr S Millar-Danks, Woodbridge
- Dr J D Griffin, Devon
- Dr R M Nicholl, Belfast
- Dr S Ray, London
- Dr F R Russell, Hartlepool
- Dr G V S Wright, Zimbabwe

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).

Please email your text and any photo to: website@rcoa.ac.uk.

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65th Anniversary Dinner

13 March 2013

The 65th Anniversary Dinner will be held on Wednesday, 13 March 2013 at 7.00 pm for 7.30 pm in Haberdashers Hall, London EC1A.

Dress will be black tie.

If you would like to attend the dinner, please contact Steph Robinson srobinson@rcoa.ac.uk

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Accredited by the College of Physicians of Edinburgh, Royal College of Physicians and Surgeons of Glasgow, Royal College of Surgeons of Edinburgh, Royal College of Surgeons of England
The 2013 RCoA Congress will be a break. A break from tradition, a break from London and a break from the norm. This Congress aims to be a truly multi-generational experience – a two-day course that has as much to offer the registrar as the established consultant.

First the trainee. The Congress evolved out of a meeting that followed on from Diplomates’ Day. We listened to feedback and have moved it out of The Smoke, made it more relevant to training (rather than trainees per se) and made it fresher, smarter and more interactive.

The subtext for the two days is: Inspiration. Each lecture session will have an inspirational lecture designed so that young undifferentiated trainees can get excited, educated and enthused about a sub-specialty. What is more: the first day has a ring-fenced session just for trainees. A session whereby trainees can get together with the great and the good of the College and discuss their CV, their career motivations and the outlook for jobs. Then there is the opportunity for the trainee to shine. We have designed a poster hall that will house up to 100 posters: from audit to full-on RCTs. Of course there is the added carrot of BJA publication for the superlative abstracts and the promise of an oral presentation and prize (from the President no less) for the very best.

Lastly, we will round the meeting up with a ‘Balloon Debate’ – this year about training. Stick around to find out what training concepts get given the heave first!

And so to the consultant. You have not been forgotten. The Congress is retaining its roots and providing a first class, far-reaching, wealth of CPD topics. But there is more. On the first day there is a workshop for consultants only. A limb blocking workshop brought to you by the bright young things from The London School of Regional Anaesthesia (LSORA). Fresh with models, presentations and the very latest pieces of kit this will give the delegates real hands-on, expert tuition in upper and lower limb sonoanatomy. But what about the lectures? They have been designed to be inspirational, innovative but overall exciting. We have very much tried to avoid ‘circuit’ speakers and topics. Preferring the fresh approach to the novel subject to get the most out of the half-hour slots. So we have a patient (a Times journalist) and clinician double act on ITU delirium; a peri-operative slot; new angles on bariatrics and some top-notch GOSH speakers. Day two sees us concentrate on sepsis, an oblique look at the world of obstetrics and some exciting presentations on humanitarian medicine.

Lastly, we are trying to break out of the staid social events that occur. Attempts are being made to secure the biggest balti restaurant in the area.

For more information about the RCoA Congress 2013 visit www.rcoa.ac.uk/node/8934
RCoA online tools

Events App
Download for exclusive information

Webcasting
View free lecture content online

Book online
Available now

@RCoANews
Follow for College wide updates

e-Learning
Anaesthesia
Learn using interactive resources

@RCoA_Events
Follow for updates and live event discussions

CPD System
Manage CPD online

RCoA e-Portfolio
Manage training portfolio online

Events Feedback
Complete online

For more information, please see www.rcoa.ac.uk.
PROGRAMME OF EVENTS 2013

HSRC UK perioperative research forum
21 January 2013 (code: B63)
New Queen Elizabeth Hospital, Birmingham
Registration fee: £45

Final FRCA course
21–25 January 2013 (code: A82)
RCoA, London
Registration fee: £360

Faculty of Pain Medicine: core competencies in mental health for pain professionals
29 January 2013 (code: C83)
RCoA, London
Registration fee: £160 (£130 for RCoA registered trainees and affiliates)

Faculty of Pain Medicine: updates in pain medicine
30 January 2013 (code: B28)
RCoA, London
Registration fee: £160 (£130 for RCoA registered trainees and affiliates)

Airway workshop
31 January 2013 (code: B53)
RCoA, London
Registration fee: £255 (£190 for RCoA registered trainees and affiliates)

Recent advances in anaesthesia, critical care and pain management
6–8 February 2013 (code: C68)
RCoA, London
Registration fee: £480

CPD study day: paediatric anaesthesia joint with APAGBI
13 February 2013 (code: F38)
RCoA, London
Registration fee: £195 (£150 for RCoA registered trainees and affiliates)

Anaesthetists as educators: teaching and training in the workplace
27–28 February 2013 (code: C84)
RCoA, London
Registration fee: £415 (£310 for RCoA registered trainees and affiliates)

The Faculty of Intensive Care Medicine annual meeting
1 March 2013 (code: F33)
RCoA, London
Registration fee: £155 (£80 for FICM Fellows and Members)

Primary FRCA masterclass
4–7 March 2013 (code: D26)
RCoA, London
Registration fee: £285

Leadership and management: leading and managing change; success with service development
5 March 2013 (code: C41)
RCoA, London
Registration fee: £215

After the Final FRCA – making the most of training years 5 to 7
6 March 2013 (code: B16)
RCoA, London
Registration fee: £160

CPD study day
11 March 2013 (code: D31)
RCoA, London
Registration fee: £195 (£150 for RCoA registered trainees and affiliates)

Anniversary meeting 2013: perioperative medicine: the future role of the anaesthetist?
13–14 March 2013 (code: A03)
Mermaid Events and Conference Centre, London
Registration fee: £435 (£325 for RCoA registered trainees and affiliates)

CPD study day: anaesthetic emergencies
27 March 2013 (code: D04)
IET Glasgow: Teacher Building
Registration fee: £195 (£150 for RCoA registered trainees and affiliates)

Joint clinical directors meeting with the AAGBI
8 April 2013
RCoA, London
By invitation only
THE EVENTS DEPARTMENT  

Research methodology workshop  
10 April 2013 (code: C85)  
Merton College, Oxford  
Registration fee: £145  

Safeguarding children: Level 3 training for anaesthetists  
30 April 2013 (code: C77)  
RCoA, London  
Registration fee: £155  

Airway workshop  
10 April 2013 (code: C12)  
RCoA, London  
Registration fee: £255 (£190 for RCoA registered trainees and affiliates)  

Cardiac disease and anaesthesia symposium  
1–2 May 2013 (code: F47)  
RCoA, London  
Registration fee: £435 (£325 for RCoA registered trainees and affiliates)  

CPD study day: educational governance and revalidation, joint with SEAUK  
15 April 2013 (code: TBC)  
RCoA, London  
Registration fee: £1195 (£150 for RCoA registered trainees and affiliates)  

Academia and armed conflict conference  
8 May 2013 (code: F73)  
RCoA, London  
Registration fee: £195  

Airway management: training the trainers  
17 April 2013 (code: A74)  
RCoA, London  
Registration fee: £245 (£185 for RCoA registered trainees and affiliates)  

UK training in emergency airway management  
13–14 May 2013 (code: B03)  
Birmingham Heartland Hospital  
Registration fee: £415  

RP study day: bariatric anaesthesia, joint with SOBA  
17 April 2013 (code: C19)  
RCoA, London  
Registration fee: £1195 (£150 for RCoA registered trainees and affiliates)  

RCoA annual congress  
16–17 May 2013 (code: D10)  
Wolfson Centre, Birmingham  
Registration fee: £385 (£285 for RCoA registered trainees and affiliates)  

Ultrasound workshop  
18 April 2013 (code: D23)  
RCoA, London  
Registration fee: £235 (£175 for RCoA registered trainees and affiliates)  

CPD study days  
21–22 May 2013 (code: B54)  
RCoA, London  
Registration fee: £350 (£265 for RCoA registered trainees and affiliates)  

Introduction to leadership and management for anaesthetists: the essentials  
21–22 May 2013 (code: B56)  
RCoA, London  
Registration fee: £405  

Airway workshop  
23 May 2013 (code: C73)  
The Carlton Hotel, Edinburgh  
Registration fee: £255 (£190 for RCoA registered trainees and affiliates)  

Advanced airway workshop  
24 May 2013 (code: D36)  
The Carlton Hotel, Edinburgh  
Registration fee: £255 (£190 for RCoA registered trainees and affiliates)  

Faculty of Pain Medicine study day  
24 May 2013 (code: B59)  
RCoA, London  
Registration fee: £160 (£130 for RCoA registered trainees and affiliates)  

Recent advances in anaesthesia, critical care and pain management  
3–5 June 2013 (code: A32)  
Eastbourne, Devonshire Park Centre  
Registration fee: £480  

Anaesthetists as educators: an introduction  
5 June 2013 (code: C18)  
RCoA, London  
Registration fee: £215 (£160 for RCoA registered trainees and affiliates)  

Ethics and the law for anaesthetists: joint with the Society for Ethics and Law in Medicine  
6 June 2013 (code: D19)  
RCoA, London  
Registration fee: £195 (£150 for RCoA registered trainees and affiliates)  

Your Events, Your Ideas  
We would welcome your suggestions for...  

events@rcoa.ac.uk
RECENT ADVANCES
IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

Date and venue:
6–8 February 2013 (code: C68)
RCoA, London

Registration fee:
£480
15 CPD credits applied for

Event organisers:
Professor P Foëx and Dr J Carlisle

DAY ONE

- 9.00 am – Registration
- College and professional affairs
  Dr J-P van Besouw, RCoA President
- Shared decision making
  Dr A Collins, Taunton
- Update in critical care
  Prof J Bion, Birmingham
- Anaphylaxis: best management
  Dr N Harper, Manchester
- Imaging pain and consciousness
  TBC
- Advances in chronic pain management
  TBC
- Cardiovascular physiology: go with the flow
  Dr M Jonas, Southampton
- Goal-directed therapy: the evidence in 2013
  Prof M Grocott, Southampton

DAY TWO

- 8.30 am – Registration
- Mechanisms of anaesthesia: what do we know today
  Prof N Franks, London
- Advances in acute pain management
  Dr J Quinlan, Oxford
- Paediatric emergencies for the generalist
  TBC
- Heart disease in pregnancy
  Dr F Walker, London
- What’s new in regional anaesthesia?
  Dr J Barcroft, Stanmore
- Major trauma and trauma systems
  Dr S Hughes, Southampton
- The evils of 100% oxygen
  Dr A Lumb, Leeds
- Management of burns: best practice in 2013
  Dr K Judkins, Pinderfields
- Anaesthesia outside the central operating department
  Dr G Jones, Leicester
- Recognition and management of the difficult airway
  Dr A McNarry, Edinburgh

DAY THREE

- 8.30 am – Registration
- Advances in sepsis management
  Dr A Gordon, London
- Perioperative optimisation: the role of CPX
  Dr J Carlisle, Torbay
- Anaesthesia for vascular surgery
  Dr J Thompson, Leicester
- Anaesthesia for the elderly and postoperative cognitive dysfunction: advanced monitoring improves outcome
  Dr D Green, London
- Depth of anaesthesia monitoring: present and future
  Dr A Absalom, The Netherlands
- Controversies in perioperative cardiac protection
  Prof P Foëx, Oxford
- Perioperative dysrhythmias
  Dr A Goodwin, Bath
- Aortic stenosis and non-cardiac surgery
  Dr J Berridge, Leeds
- Haematological management of the high-risk surgical patient
  Dr R Telford, Exeter
- 3.55 pm – Close
CPD STUDY DAY:
PAEDIATRIC ANAESTHESIA
JOINT WITH APAGBI

Date and venue:
13 February 2013 (code: F38)
RCoA, London

Registration fee:
£195 (£150 for registered trainees and affiliates)
Approved for 5 CPD credits

Event organiser:
Dr N Morton

- 8.45 am – Registration
- Care of the surgical neonate: lessons from NCEPOD 2012 (2D01, 2D02, 3D00)
  Dr K Wilkinson, Norwich
- Useful sedation techniques outside the operating theatre (2D06)
  Dr M Sury, London
- A practical guide to TIVA in children (2D02)
  Dr O Bagshaw, Birmingham
- Does awareness occur in children and should we measure depth of anaesthesia in children? (2A04, 2D02)
  Dr A Calder, Glasgow
- A systematic approach to paediatric airway problems (2D02, 2A01, 3A01)
  Dr R Walker, Manchester
- New devices for the normal and abnormal paediatric airway (2A01, 2D02)
  Dr C Gildersleve, Cardiff
- Pain management in children: what is the latest evidence? (2D05)
  Dr G Williams, London
- Improving pain at home after surgery in children (2D05, 2D02)
  Dr G Bell, Glasgow
- 5.30 pm – Close

AFTER THE FINAL FRCA:
MAKING THE MOST OF TRAINING YEARS 5 TO 7

Date and venue:
6 March 2013 (code: B16)
RCoA, London

Registration fee:
£160
Approved for 5 CPD credits

Event organisers:
Dr D Ross-Anderson and Dr A McGlennan

- 8.45 am – Registration
- Introduction and welcome
  Dr Alan McGlennan and Dr Davina Ross-Anderson, London
- ST 5–7 Curriculum Requirements and Spiral Learning
  “What do you have to fit the exciting choices around?”
  Dr D Nolan, Manchester
- How I became a specialist
  ICM – Dr G Wares, London
  Paediatrics – Dr B O’Neill, London
  Cardiac – Dr N Jones, London
  Regional – Dr M Oldman, Plymouth
  Neuroanaesthesia – Dr T Gregory, Cambridge
  Perioperative Medicine – Dr M Edwards, London
- How to keep up to date and versatile
  Dr D Ross-Anderson, London
- What do you need on your CV?
  Dr A McGlennan, London
- Workshops to include:
  Workshop 1
  The ‘Education’ Tick Box
  Dr Wares, Dr McGlennan and Dr Oldman
  Workshop 2
  The ‘Management’ Tick Box
  Dr Ross-Anderson, Dr Jones and Dr Gregory
  Workshop 3
  The ‘Research’ Tick Box
  Dr Edwards and Dr O’Neill
- Extra Time. Higher Degrees, Out of Programme Time, Fellowships and Locum Consultancy
  Dr S Edgar, Edinburgh
- 4.15 pm – Close
ANNIVERSARY MEETING 2013:
PERIOPERATIVE MEDICINE: THE FUTURE ROLE OF THE ANAESTHETIST?

Date and venue:
13–14 March 2013 (code: A03)
The Mermaid Conference and Events Centre,
Puddle Dock, Blackfriars, London

Registration fee:
£435 (£325 for RCoA registered trainees and affiliates)
10 CPD credits applied for

Event organisers:
Dr R Moonesinghe and Dr A Cooper

DAY ONE
■ 8.45 am – Registration

SESSION 1: HEARTS AND MINDS
■ Perioperative echocardiography in non-cardiac surgery – what is the evidence?
  Dr N Morgan-Hughes, Sheffield
■ Planning the perioperative management of the potentially delirious patient
  Dr R Sanders, London
■ Cardiac complications after major non-cardiac surgery
  Dr G Ackland, London

SESSION 2: THE ROLE OF THE ANAESTHETIST
AT HOME AND ABROAD...
■ Europe
  Dr B Walden, Geneva
■ The US
  Dr T Roche, Seattle, USA

THE MACINTOSH LECTURE: PERIOPERATIVE MEDICINE:
OPPORTUNITY OR THREAT?
Dr R Pearse, London

SESSION 3: PATHWAYS TO SUCCESS...
WORKING WITH OTHER SPECIALTIES
■ Orthogeriatric care
  Professor O Sahota, Nottingham
■ Engaging primary care to improve surgical outcome
  Dr J Kitlowski, Rotherham

ANNUAL GENERAL MEETING
SESSION 4: HEALTH SERVICES RESEARCH CENTRE
■ National Audit Projects and quality improvement in perioperative medicine
  Dr T Cook, Bath
■ Quality feedback to clinicians: which indicators and how?
  Dr J Benn, London
■ Which perioperative complications matter, and why?
  Dr R Moonesinghe, London
■ 5.20 pm – close of meeting

DAY TWO
■ 8.30 am – Registration

SESSION 5: EMERGENCY SURGERY
■ Emergency laparotomy – the ultimate perioperative challenge?
  Dr D Murray, Middlesbrough
■ Optimising management of hip fractures in 2013 – are we any further forward?
  Dr R Griffiths, Peterborough
■ Organising emergency surgical services – do we need to think differently?
  Dr C Peden, Bath

SESSION 6: DEVELOPING THE EVIDENCE BASE
■ Systematic reviews in perioperative medicine
  Professor A Smith, Lancaster

RANK LECTURE: HAVE LARGELY RANDOMISED
CONTROLLED TRIALS DELIVERED?
Professor P Myles, Australia

SESSION 7: THE PERIOPERATIVE PAIN PHYSICIAN
■ Multi-modal perioperative analgesia
  Dr A Vickers, Lancaster
■ Short and long-term effects of acute perioperative pain
  Dr R Langford, London
■ Enhancing recovery with regional anaesthesia
  Dr D Kamming, London

SESSION 8: BLOOD AND FLUIDS
■ Fluid restriction for abdominal surgery
  Professor P Myles, Australia
■ Should we abandon colloids perioperatively?
  Dr T Roche, Seattle, USA
■ How low should we go... restrictive transfusion policy
  Dr R Gill, Southampton
■ 5.00 pm – Close
DAY ONE
9.30 am – Registration

SESSION 1: ITU
Intensive care for the bariatric patient
Dr M Bellamy, Leeds
ITU psychosis: the patient perspective
Mr D Aaronovitch, Columnist on The Times
ITU psychosis: the scientific perspective
Dr V Page, Watford

SESSION 2: FLUID MANAGEMENT
Update on fluid therapies
Dr M Hamilton, London
The future of perioperative medicine
Dr R Pearse, London

FELLOWSHIP BY ELECTION AND KEYNOTE LECTURE: PROFESSOR G MARX
Fellowship by election presentation
Dr J-P van Besouw, RCoA President
Keynote Lecture: Monitoring of intravascular fluid administration
Professor G Marx, Germany

LUNCH
Opportunity for trainees to meet RCoA Council Members

SESSION 3: PEDIATRICS AND BARIATRICS
Brain development and anaesthesia
Dr S Walker, London
My most memorable cases
Dr P Evans, London
Metabolic syndrome drug dosing school in the bariatric patient
Dr M Margarson, Chichester

WORKSHOPS (optional)
Consultants: Ultrasound stations: upper limb, lower limb, epidural (£25 limited availability)
Trainees: CV workshop (FREE)

DAY TWO
8.30 am – Registration

SESSION 4: SEPSIS
New therapies for sepsis in ITU
Professor G Marx, Germany
Surviving sepsis update
Dr R Daniels, Birmingham
Sepsis in obstetrics
Dr N Lucas, London

SESSION 5: OBSTETRICS
Remifentanil for obstetric analgesia – has its time come or has it passed?
Dr D Hill, Belfast
Haematological aspects of obstetrics
Dr A England, London

LUNCH
Opportunity for trainees to meet RCoA Council Members

SESSION 6: HUMANITARIAN ANAESTHESIA
Capacity building in disaster areas
Dr E McCoy, Belfast
Military trauma to civilian practice
Dr C Park, Birmingham
Disaster trauma register
Dr A Redmond, Manchester

SESSION 7: CLOSING
Training balloon debate
Poster prizes and presentations presented by the RCoA President

17.00 pm – Close
Event organiser: Dr A McGlennan
CAR DiAC DiSEASE AND ANAESTHESIA SYMPOSIUM

Date and venue: 1–2 May 2013 (code: F47)  
RCoA, London  
Registration fee: £435 (£325 for RCoA registered trainees and affiliates)  
Applied for 10 CPD credits  
Event organisers: Professor P Foëx and Dr H Higham

DAY ONE
- 8.55 am – Registration  
SESSION 1: PREOPERATIVE ASSESSMENT OF THE CARDIAC PATIENT  
- Human factors and outcome in the cardiac patient  
- Reducing perioperative risk in non-cardiac surgery: Should we screen for cardiac disease?  
- Cardiopulmonary testing (CPX) for all?  
SESSION 2: THE ADULT WITH CONGENITAL HEART DISEASE  
- Overview of grown-up congenital heart disease  
- Anaesthesia for non-cardiac surgery in the grown-up with congenital heart disease  
SESSION 3: THE PATIENT WITH CHRONIC HEART FAILURE  
- Pathophysiology of heart failure  
- Anaesthetic management of patients with heart failure/heart transplant  
- The role of inotropic support  
SESSION 4: COMPLEX PROBLEMS IN FREQUENT PATIENTS  
- Heart disease in pregnancy  
- Pacemakers, internal defibrillators and cardiac resynchronisers: anaesthetic challenges  
KEYNOTE LECTURE  
- Blood pressure control and clinical outcomes in the perioperative setting  

DAY TWO
- 8.45 am – Registration  
SESSION 5: THE SURGICAL PATIENT WITH CORONARY DISEASE  
- Pathophysiology of coronary heart disease  
- Do percutaneous interventions protect the surgical patient?  
- Coronary stents: managing patients or platelets?  
SESSION 6: VALVULAR HEART DISEASE  
- Pathophysiology of valvular heart disease  
- Anaesthetic management of the patient with valvular heart disease  
KEYNOTE LECTURE  
- The anaesthetist as the preoperative physician  
SESSION 7: CONTROVERSIES AND CHALLENGES  
- Interventional cardiology and the anaesthetist  
- BNP has come of age  
- Optimising high risk patients: how, where and why?  
- 4.05 pm – Close

ACADEMIA AND ARMED CONFLICT CONFERENCE

Date and venue: 8 May 2013 (code: F73)  
RCoA, London  
Registration fee: £195

Lecture topics will include:
- Deployed pre-hospital care  
- The challenges of undertaking higher research degrees within the military environment  
- Altitude and hypoxia  
- Traumatic cardiac arrest  

The day will provide delegates with an appreciation of:
- Recent advances in military research including effects of altitude, drug pharmacology in hypovolaemia, and pulmonary injury in organophosphate poisoning  
- How military anaesthetic research is conducted in different environments; specifically the challenges involved in undertaking research in the military setting  
- How the military and civilian research communities may best interact under the umbrella of the National Institute of Academic Anaesthesia.

Poster presentation  
Trainees are invited to submit an abstract on the subject of research, audit and surveys from the Defence Medical Services and Defence Science and Technology Laboratory. Abstracts may be selected for verbal presentation or as poster displays and abstract guidelines can be requested from cbunnell@rcoa.ac.uk. The deadline for abstracts is Monday 25 March 2013.

Further details about this event can be found on the NIAA website (www.niaa.org.uk).
**THE EVENTS DEPARTMENT**

**FACULTY OF PAIN MEDICINE**
of the Royal College of Anaesthetists

**CORE COMPETENCIES IN MENTAL HEALTH FOR PAIN PROFESSIONALS**

Date and venue: 29 January 2013 (code: C83)
RCoA, London

Registration fee: £160 (£130 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

- Recognising alcohol and drug addiction, understanding treatments and signposting sources of support
  Dr Emma Whicher, London
- Depression and its treatment: identifying risk of self harm
  Dr Lisa McClelland, Exeter
- Common personality disorders and how they may present barriers to engagement with pain management
  Dr Jim Bolton, Surrey
- Somatisation disorders
  Dr Charlotte Feinmann, London
- Case based discussions
- Clinical Support
  Dr Johanna Herrod, Bristol

**UPDATES IN PAIN MEDICINE**

Date and venue: 30 January 2013 (code: B28)
RCoA, London

Registration fee: £160 (£130 for RCoA registered trainees and affiliates)
Approved for 5 CPD credits

- Updates on psychology in pain medicine
  Prof Chris Eccleston, Bath
- Updates on opioids for non-cancer pain management
  Dr Cathy Stannard, Bristol
- Investigating a patient with pain
  Dr Richard Sawyer, Plymouth
- Updates on self-management in pain medicine
  Dr Alf Collins, Somerset
- Topics on philosophy and ethics in pain medicine
  Dr Michael Platt, London

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**The Faculty of Intensive Care Medicine**

**ANNUAL MEETING**

Date and venue: 1 March 2013 (code: F33)
RCoA, London

Registration fee: £155 (£80 for trainees)
Approved for 5 CPD credits

Introduction: Professor J Bion (Dean)

**SESSION 1: CHANGING THE HEALTHCARE SYSTEM**
- The post bill NHS in practice
  Dr J Dixon, London
- Education and training in the new NHS
  Professor D Black, London
- The role of college and faculties
  Professor T Stephenson, London

**SESSION 2: CHANGING PRACTICE**
- The future hospital
  Professor T Evans, London
- Commissioning quality in intensive care
  Dr M Britnell, London
- Revalidation: will it lead to better doctors?
  Sir P Rubin, GMC, London

**SESSION 3: NEW KNOWLEDGE IN CRITICAL CARE**
- Sepsis
  Dr A Gordon, London
- Head and spinal injury
  Professor D Menon, Cambridge
- ALI
  Professor G Perkins, West Midlands
- Genomics
  Professor C Hinds, London

**SESSION 4: FACULTY ANNUAL REPORT AND AWARD OF FELLOWSHIPS**
- Annual Faculty Lecture
  Professor Lord Darzi, London

5.00 pm
Close of meeting followed by canapés reception

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**FFPMRCA EXAMINATION TUTORIALS**

With the introduction of the FFPMRCA examination, the Faculty will be running bi-annual examination tutorials (before each exam) to assist the trainees in preparation for the exam. These are interactive days, covering a wide range of topics through workshops and lectures; where the trainees are expected to pre-prepare for the day to encourage discussion and interactive learning.

The next tutorials are scheduled for:
- 7 June 2013
- 11 October 2013
**PRIMARY FRCA OSCE/SOE COURSE**

22–23 April 2013
24–25 April 2013

- Mock exams: OSCE & SOE with individual feedback
- Revised material based on previous feedback
- Group OSCE/SOE practice with experienced faculty
- Revision of past exam questions
- Clinical skills/practical procedures on simulator
- Communication skills: simulated patients
- Key topics in anatomy
- Radiology for Primary FRCA

Registration fee: £200
Breakfast, lunch & refreshments are included

For further details please visit our website
www.anaesthetics.uk.com
Or contact Rachel Davies:
rachel.davies2@uhcw.nhs.uk
024 7696 8722

**COVENTRY PRIMARY FRCA MCQ/SBA COURSE**

21–23 May 2013

- A three-day course with intensive MCQ/SBA practice in physiology, pharmacology, physics and clinical measurement under strict exam conditions
- A three-hour test paper on day three and candidates will receive feedback on their performance
- Over 350 MCQs and 180 SBAs will be analysed
- Access to pre-course material including past MCQs
- Access to all course presentations and further MCQs on the web
- Interactive discussion of Single Best Answer questions using Turning Point technology
- Pre-course MCQ practice and feedback starts 6 weeks prior to the course

PLACES ARE LIMITED SO PLEASE APPLY EARLY

Registration fee: £160 includes a copy of SBA – Basic Sciences book, breakfast, lunch and refreshments

For further details please contact Rachel Davies:
rachel.davies2@uhcw.nhs.uk
024 7696 8722
www.anaesthetics.uk.com

**COVENTRY AIRWAY MANAGEMENT COURSE**

19 March 2013 at University Hospital, Coventry

- Basic fibreoptic intubation
- Oral and nasal fibreoptic intubation
- ILMA and C Trach
- Fibreoptic intubation through LMA
- Fibreoptic intubation through ILMA
- Videolaryngoscopes
- Lung isolation techniques
- Optimisation of direct laryngoscopy
- TTJV and cricothyroidotomy
- Human factors and non-technical skills
- Awake fibreoptic intubation
- Extubation

PLACES ARE LIMITED SO PLEASE APPLY EARLY

Registration fee: £95
includes refreshments and lunch

For further details please contact Rachel Davies:
rachel.davies2@uhcw.nhs.uk
024 7696 8722
www.anaesthetics.uk.com

**FINAL FRCA MCQ/SAQ COURSE**

18–20 February 2013 at University Hospital, Coventry

- MCQ practice in medicine, surgery, clinical measurement, intensive care medicine, anaesthesia and pain management under strict exam conditions. SBA practice in clinical anaesthesia, pain and intensive care medicine.
- SAQ practice in intensive care medicine, neuroanaesthesia, chronic pain, cardiac anaesthesia, paediatric anaesthesia and trauma.
- Mock exam in SAQ and MCQ/SBA.
- Interactive discussion of Single Best Answer questions using Turning Point technology.
- Pre-course SAQ practice and feedback starts 2 months prior to the course.

Registration fee: £200

For further details please visit our website
www.anaesthetics.uk.com or www.mededcoventry.com

Or contact Rachel Davies:
rachel.davies2@uhcw.nhs.uk
024 7696 7083
www.anaesthetics.uk.com or www.mededcoventry.com
Primary OSCE/Viva crammer
17–19 April 2013
Fee: £395.00 – for full course
£250.00 – for VIVA only
£200.00 – for OSCE only

Intense three-day course for Primary examination. Candidates will attend nine viva and 32 OSCE stations. Intense coaching in OSCE and Viva technique via interactive tutorials.

For an application form, please contact:
The Department of Academic Anaesthesia,
Cheriton House, The James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW
claire.thornley@stees.nhs.uk
01642 854601
PLACES ARE LIMITED

Final FRCA crammer courses
28–30 January 2013 (MCQ/SAQ)
13–14 May 2013 (Viva)
Fee: £250.00 – VIVA
£300.00 – MCQ/SAQ

Programme includes full mock MCQ and SAQ exam plus tutorials. Viva course includes intense and realistic formal Viva practice under exam conditions with Consultant mock examiners. Candidates receive personalised one-to-one feedback on techniques.

For an application form, please contact:
The Department of Academic Anaesthesia,
Cheriton House, The James Cook University Hospital, Marton Road, Middlesbrough TS4 3BW
claire.thornley@stees.nhs.uk
01642 854601
PLACES ARE LIMITED
Invitation to submit abstracts for a poster presentation at the annual College Tutors Meeting at Manchester University on 12 and 13 June 2012. The abstract should be related to training in anaesthesia, critical care or pain medicine and should conform to the guidelines, available from the College website at www.rcoa.ac.uk/node/8938.

Abstracts should be submitted to kmorris@rcoa.ac.uk no later than 22 February 2013. The authors of the best abstracts will be invited to submit a poster for the meeting and the authors of the best three abstracts will be invited to present their work at the plenary session of this national meeting. If chosen you will be notified by Thursday 28 March 2013. There will be a first prize of £500.00, a certificate and publication of papers in the College Bulletin, there will also be cash prizes for second and third places. All abstracts that go forward to the meeting will receive recognition.

Full details are available on the College website or by contacting Karen Morris by email kmorris@rcoa.ac.uk or by telephone 020 7092 1573.
THE MSA IS PLEASED TO OFFER

VERY BEST WISHES FOR 2013

TO ALL CONTRIBUTORS, ALUMNI AND CANDIDATES

Final Courses 2013

MCQ/SBA 25–31 January
SAQ Weekend 15–17 February
SAQ Weekend 22–24 February
Booker 24 February–1 March
Viva Revision 11–17 May
Viva Weekend 14–16 June

Primary Courses 2013

MCQ/SBA 16–22 January
Selective 18–22 March
Viva Revision 18–23 April
OSCE/Orals 3–10 May
MCQ/SBA 25–31 May

The SAQ Writers Club

Candidates for the Autumn examinations at both the RCoA and CAI are strongly advised to join sooner than later. The sooner you join, the greater the benefit.

For further information on the Writers Club please visit our website at www.msoa.org.uk

THE SELECTIVE COURSE

In preparing for the Primary Examination, many candidates find there are areas of theory that have been poorly taught or not understood in sufficient depth.

We have assembled a consultant faculty of subject matter experts who will use didactic lectures, questions and answers, homework, demonstrations, MCQs and handouts to illuminate their subjects. Places are available for external candidates planning to take the Primary MCQ in June 2013.

Mersey Deanery candidates are all encouraged to attend.

We expect that topics covered will include:

- Acid-base
- Anatomy lower limb
- Breathing systems
- Diathermy/electric hazards
- Exam gems
- Extreme physiology
- Life support
- Metabolism
- Mechanics of respiration
- Oxygen/CO2 transport
- Pharmacokinetics
- Receptors
- Renal
- Respiration
- Statistics

Candidates should be on the threshold of the Primary Examination.

The 5 day course (18–22 March) will be held at the Liverpool Medical Institute in central Liverpool.

Lunches, refreshments and car parking will be included.

Course cost is £400

Homework menu will be provided to applicants.

For details and applications www.msoa.org.uk
## Contact Information

### Chief Executive and Director of Finance
- **Kevin Storey**  
  020 7092 1612

### Deputy Chief Executive and Director of Professional Standards
- **Charlie McLaughlan**  
  020 7092 1613

### Director of Education and Research
- **Sharon Drake**  
  020 7092 1613

### Director of Training and Examinations
- **Richard Bryant**  
  020 7092 1613

### Chief Executive’s Office

<table>
<thead>
<tr>
<th>Position</th>
<th>Name</th>
<th>Email</th>
<th>Phone</th>
</tr>
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<tbody>
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<td>020 7092 1712</td>
</tr>
<tr>
<td>Membership and subscriptions</td>
<td></td>
<td><a href="mailto:subs@rcoa.ac.uk">subs@rcoa.ac.uk</a></td>
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### Education and Research Directorate

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<tr>
<th>Position</th>
<th>Name</th>
<th>Email</th>
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<tbody>
<tr>
<td>Education and Research Manager</td>
<td>Mary Casserly</td>
<td><a href="mailto:events@rcoa.ac.uk">events@rcoa.ac.uk</a></td>
<td>020 7092 1680</td>
</tr>
<tr>
<td>Faculties Manager</td>
<td>Daniel Waeland (FPM &amp; FICM)</td>
<td><a href="mailto:fpm@rcoa.ac.uk">fpm@rcoa.ac.uk</a></td>
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<tr>
<td>Human Resources Manager</td>
<td>Isma Adams</td>
<td><a href="mailto:hr@rcoa.ac.uk">hr@rcoa.ac.uk</a></td>
<td>020 7092 1542</td>
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<tr>
<td>e-Learning Anaesthesia</td>
<td></td>
<td><a href="mailto:e-LA@rcoa.ac.uk">e-LA@rcoa.ac.uk</a></td>
<td>020 7092 1542</td>
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<tr>
<td>Meetings and Events</td>
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<td><a href="mailto:events@rcoa.ac.uk">events@rcoa.ac.uk</a></td>
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<tr>
<td>National Institute of Academic Anaesthesia</td>
<td></td>
<td><a href="mailto:info@niaa.org.uk">info@niaa.org.uk</a></td>
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### Professional Standards Directorate

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<tr>
<th>Position</th>
<th>Name</th>
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<tr>
<td>Professional Standards Manager</td>
<td>Bob Williams</td>
<td><a href="mailto:standards@rcoa.ac.uk">standards@rcoa.ac.uk</a></td>
<td>020 7092 1694</td>
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<tr>
<td>Revalidation and CPD Manager</td>
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<tr>
<td>Advisory Appointments Committees</td>
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<td><a href="mailto:aac@rcoa.ac.uk">aac@rcoa.ac.uk</a></td>
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<td>Anaesthesia Review Teams</td>
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<td><a href="mailto:art@rcoa.ac.uk">art@rcoa.ac.uk</a></td>
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<tr>
<td>Bulletin</td>
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<td><a href="mailto:bulletin@rcoa.ac.uk">bulletin@rcoa.ac.uk</a></td>
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<tr>
<td>CPD and Revalidation</td>
<td></td>
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<tr>
<td>Media Advisor</td>
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<td><a href="mailto:simonandrewscott@hotmail.co.uk">simonandrewscott@hotmail.co.uk</a></td>
<td>07730 989692</td>
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<tr>
<td>Patient Safety</td>
<td></td>
<td><a href="mailto:salg@rcoa.ac.uk">salg@rcoa.ac.uk</a></td>
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<tr>
<td>Presidential Secretariat</td>
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<td><a href="mailto:president@rcoa.ac.uk">president@rcoa.ac.uk</a></td>
<td>020 7092 1600</td>
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<tr>
<td>Website</td>
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### Training and Examinations Directorate

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<tr>
<td>Examinations Manager</td>
<td>Graham Clissett</td>
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<tr>
<td>Training Manager</td>
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<td>e-Portfolio Project Manager</td>
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<tr>
<td>Equivalence</td>
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<tr>
<td>International Programmes Co-ordinator</td>
<td></td>
<td><a href="mailto:ip@rcoa.ac.uk">ip@rcoa.ac.uk</a></td>
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<tr>
<td>Regional Representatives Support</td>
<td></td>
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<tr>
<td>SAS and Specialty Doctors</td>
<td></td>
<td><a href="mailto:cgc@rcoa.ac.uk">cgc@rcoa.ac.uk</a></td>
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<td>Trainees</td>
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<td>Quality Assurance</td>
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### The Royal College of Anaesthetists

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