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BULLETIN
of The Royal College of Anaesthetists

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

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From the Editor

Welcome to the summer edition, but previous experience makes me feel that the few sunny days we enjoyed in May could be all we see. This edition has a ‘quality’ agenda running through its pages; timely given events this year to date!

Our guest editorial is an example of the involvement of anaesthetists in the important developing arena of perioperative care. This incidentally was a central theme from this year’s anniversary meeting and is an area of significant interest to the College and specialty. Venous thromboembolism (VTE) is of importance to us in the care of our patients and the charity Lifeblood was established to increase awareness of thrombosis. Lifeblood has been instrumental in raising the issue of hospital-acquired clots, and has actively campaigned for the UK Parliaments to promote the NHS having a national inpatient VTE policy. To celebrate their 10th anniversary, Lifeblood and the All-Party Parliamentary Thrombosis Group distributed awards to hospitals for their achievements in VTE assessment and prophylaxis. Two hospitals in East Anglia received awards for being the best performing Trust and having the best ‘VTE Prevention Programme’. Anaesthetic colleagues were instrumental in designing these hospital’s policies, clearly important in perioperative care. While NICE guidance and CQUIN targets have improved assessment rates, all however in this area is not without some degree of controversy.

I am sure that it has not escaped your notice that the RCoA has been developing its voluntary Anaesthesia Clinical Services Accreditation (ACSA) under the leadership of Peter Venn and the Professional Standards Directorate. ACSA will be launched just prior to you reading this, having completed its pilot project. It is considered to be of such importance that the medical director of NHSE Sir Bruce Keogh attended the launch among other leaders of national bodies. While it is not a response to the Francis report, the timing of the initiative co-incides rather well and the RCoA is receiving interests from several Trusts to engage in ACSA. I urge clinical directors and all consultants to consider if your department’s practices meet the standards of GPAS (www.rcoa.ac.uk/gpas2013). Engagement with ACSA will be a major way to improve quality of care and receive recognition for doing so (something to interest CEOs) which neatly brings me to the second major article in this edition.

Improvement Science (IS) or Quality Improvement may be a new concept to some of us but since it is being incorporated into the CCT curriculum we all need to embrace its concepts. Professor Kevin Rooney and Dr Justin Phillips outline the history and principles behind IS which in time will promote person-centred perioperative care. You will not have heard the last of this topic. Quality is again the underlying current in our regular revalidation, NIAA and FICM articles. Should of course you feel that standards in your hospital are not what you aspire to despite your best efforts, then your eyes should turn to our PLG column featuring the art of whistle blowing.

It has been suggested that commencing a career in anaesthesia is a daunting experience, and indeed it maybe that re-starting one is even more challenging. We feature articles on GASagain, a course developed to ease a return to work, and detail the RCoA Guide for Novices which will be given to every new core anaesthetic trainee this summer, essential reading for all education supervisors. However before we can even get to this position, trainees need to want to apply to anaesthesia and I am delighted to include the reflections of medical student Stephanie Bellamy, on her student elective and hope that she is more successful in her core training interviews than Britain’s latest venture into Eurovision (you will need to read it to appreciate that link!) We have a new initiative at this years College Tutor meeting in having a trainee poster competition and we include three abstracts to wet the ‘Tutor’s appetites. The next ‘competition’ for Fellows lies in the ‘Lives of Fellows’ section in the back pages with some names from the archived photograph from the March edition. I hope you enjoy this edition and welcome feedback and of course your articles and correspondence. Enjoy your summer break!
Congratulations and celebrations?

‘You can’t help getting older, but you don’t have to get old’
[GEORGE BURNS – AMERICAN COMEDIAN AND WRITER]

The NHS, the founding principles of which were universal accessibility of healthcare with free access at point of delivery, financed from central taxation, celebrates its 65th anniversary on 5 July. The College will be celebrating this event through a specially commissioned short film. The film will mark significant developments in our specialty from 1948 to the present time through a series of short interviews with our Fellows.

Many changes have occurred since the inception of the NHS. The provision of services has been the provenance of state controlled and funded institutions with policy determinations being made through central (UK) and more recently the devolved governments. The escalating demand for healthcare – with the associated costs – has led to progressive government attempts, from all parties, to ‘marketise’ services. For anaesthesia, intensive care and pain medicine there are real concerns on the stability of the training and working environment in the event of service reconfiguration to an AQP. In terms of patient safety we are concerned that the current structure for the provision of anaesthetic services within the non-NHS sector is largely dependent on consultants working as independent practitioners without the supporting governance structures so well developed in NHS departments.

The issue surrounding the implementation of Regulation 75 is one confined to England; however, Scotland, Wales and Northern Ireland have a variety of issues specific to Fellows and Members who work in those countries. The Advisory Boards in the devolved nations are increasingly effective in informing governmental thinking on the provision of services and the delivery of training within their jurisdictions facilitated through our regular dialogue with the CMOs.

Silver lining

Another anniversary to celebrate, in the autumn, will be the 25 years since the Faculty of Anaesthetists became the College of Anaesthetists. The landscape of anaesthesia, and healthcare more generally, has changed immeasurably in that time and is likely to change even more over the coming 25 years. The College will celebrate its Silver Jubilee by holding a Jubilee Current Concepts Symposium on 10–11 October 2013 here at Churchill House, which is slightly earlier in the calendar than normal. The focus of this meeting will be on the next 25 years and it is our intention that the programme will be largely delivered by the rising stars in anaesthesia, intensive care and pain medicine giving us their insight into how they see our specialty developing over the next 25 years as we progress to our Golden Jubilee.

One step beyond

Now that the dust has settled following the publication of the Francis Inquiry report, organisations have had time to scrutinise the recommendations and to develop their ideas as to how they can produce deliverable outcomes. The government in its response has highlighted four key actions.

■ Put in place a culture of zero-harm and compassionate care.
■ Detect problems quickly.
■ Accountability for wrongdoers.
■ Leadership and motivation of NHS and social care staff.

The colleges have also prioritised the recommendations and will be progressing agendas to implement these to incorporate specialty specific advice. It will be of no surprise that
the focus of our College activity will be on standards in training and service delivery, patient safety, leadership and transparency. The College developed anaesthesia clinical services accreditation (ACSA), which was formally launched in June and has been warmly received by many agencies responsible for addressing the response to the Francis report and is seen to be a vehicle to help deliver a better and safer service to patients and staff. As a College we have regular meetings with all those involved in the delivery of training including HEE, GMC and the Advisory Boards as well as our recently appointed Lead Dean for Anaesthesia, Air Commodore Alison Amos. The College, through the Chair of the Safe Anaesthesia Liaison Group (SALG), has representation on the Surgical Safety Committee and is currently represented on the Faculty of Medical Leadership and Management by the Chair of the CD Network.

Shaping our views
The College was fortunate to be one of a select group of organisations to give oral evidence to the Shape of Training Review. Concerns had been expressed around the UK at the direction of travel of this initiative particularly at the prospect of a foreshortened training programme. In giving our evidence we took consideration of the opinion provided by others and also from discussions with trainers, trainees and clinical directors. The review is of course broad ranging and non-specialty specific but initial discussions indicate a desire for a more generalist approach to training, with sub-specialty training being the exception rather than the norm. Whether further training in a sub-speciality is delivered within the timeframe of the CCT, or becomes the responsibility of a local provider instituted to reflect a local need, will be a point for further discussion and comment.

The impact of European working time directives on the provision of training continues to cause concern in a number of quarters; this, coupled with patient and GMC concerns on the EU directive on mutual recognition of professional qualifications, has led the government to explore these areas of policy and seek further clarification on the impact on UK trainees and on patient safety. Whilst this review will not herald a return of the 100-hour week, it may seek to deliver a more flexible approach than that currently in force. Colleges have been keen to stress to government that, as with other areas of healthcare provision, service reconfiguration needs to be considered as part of the discussion.

Learning from others
The Royal College of Psychiatrists has produced an excellent report on whole person care (www.rcpsych.ac.uk/pdf/OP88.pdf). Whilst the primary focus of the report is the gap in the provision of services between mental and physical health, the report highlights the impact of mental health problems on the outcomes for patients with mental health problems with co-existing acute illness. As an acute care specialty we sometimes lose sight of the additional burden that a mental health problem places on a patient’s ability to recover. As the burden of mental health problems increases with our aging population, our peri-operative care pathways need to be able to recognise and deal with the consequences of mental health as a comorbidity.

The Royal College of Paediatrics and Child Health has published a report assessing the compliance of paediatric services against RCPCH standards for the provision of service instituted in 2011 (www.rcpch.ac.uk/child-health/standards-care/health-policy/facing-future/facing-future). The principal finding was the lack of availability of trained staff to deal with out-of-hours work in the evenings and at weekends. The solutions included a requirement to appropriately reconfigure services to ensure that safe and timely care can be provided.

To infinity and beyond?
The College e-Portfolio has passed 100,000 assessments. Congratulations to Dr Jasmina Perinpanayagam and her trainer Dr Jeremy Boyle at Kingston Hospital, Surrey, which by coincidence is my local DGH. I should like to take the opportunity to thank Andy Leabourne, our e-Portfolio Administrator, for his hard work in supporting the delivery of this project, which has revolutionised the assessments process.

We are also very proud to announce the arrival of the 5,000th user of our online CPD system. The Revalidation and CPD Team, Don Liu and Chris Kennedy, have driven engagement with this service from the College up to the launch of revalidation and beyond. There is a notice on this achievement on Page 67 and the comments from our 5,000th customer, Dr Mark Kubli, mirror many of the compliments received by the team.

May and June are by tradition some of the busiest months of the College calendar and this year has been no different. I, like all of you, am looking forward to a summer holiday.
Venous thromboembolism and the anaesthetist

Background
Venous thromboembolism (VTE) is a major health burden with an overall incidence of 100 per 100,000 per annum. Approximately two-thirds of these are accounted for by deep vein thrombosis (DVT) and one-third by pulmonary embolism (PE). Sudden unexpected death is the presenting feature in approximately 20% of PEs with mortality progressing to 30% within 30 days. In those patients who survive there is an estimated 5% annual recurrence risk, 1% two-year risk of pulmonary hypertension and a 28% 20-year risk of post-thrombotic syndrome.

Over the past 40 years, and particularly since the publication of the first trial to demonstrate the benefit of heparin prophylaxis in 1975, the risk factors for VTE and strategies for its prevention have been extensively studied. Over that time it has become universally accepted that inpatients and those in the perioperative period have an increased risk of VTE. It is estimated that the prevalence of PE for inpatients is approximately 1% and that PE accounts for 10% of hospital deaths.

In 2005 the House of Commons Health Committee published a report outlining that there was an estimated 25,000 people in the UK who die every year from preventable hospital acquired VTE. Moreover, despite the wealth of evidence available at that time, 72% of patients deemed to be at higher risk of VTE did not receive any form of either mechanical or pharmacological prophylaxis whatsoever. As a result, the National Institute for Health and Clinical Excellence (NICE) produced guidance in 2007, ‘Venous thromboembolism: reducing the risk of venous thromboembolism in inpatients undergoing surgery.’ More recently, in January 2010 the guidance was broadened to cover all hospitalised patients with the publication of NICE clinical guideline 92, ‘Reducing the risk of venous thromboembolism in patients admitted to hospital.’ For the past five years, in an effort to reduce deaths from hospital acquired VTE, hospitals have been invited to submit their VTE assessment rates and compliance with VTE prophylaxis to the All Party Parliamentary Thrombosis Group.

In December 2009, the Department of Health (DH) published their intention that VTE risk assessment would be a Commissioning for Quality and Innovation (CQUIN) target. The DH stated that payment would only be triggered if an individual Trust ensured that greater than 90% of its inpatients had undertaken a VTE risk assessment. The scheme was implemented in July 2010. Prior to the scheme being introduced, only 47% of adult inpatients were risk assessed for VTE: subsequently 84% of adult patients were risk assessed for VTE on admission in the first quarter of 2011/2012 (Figure 1).

Due to our ubiquitous roles in perioperative medicine, anaesthetists have been pivotal in the introduction of the local policies and procedures that hospitals have implemented to achieve this dramatic improvement.

Whilst it is undeniable that the NICE guidance and the CQUIN targets have improved compliance with VTE assessment, there are several areas surrounding peri-operative VTE prophylaxis where the recommendations are based mainly on expert opinion, and further research is required to reduce controversy. The purpose of this editorial is to review some selected areas of controversy.

VTE prophylaxis in day surgery
The NICE 92 Guidance recommends risk assessment for day surgery patients according to the same criteria as for inpatients. Any single risk factor places the patient in the high risk group. This immediately necessitates both mechanical and chemical prophylaxis unless contraindicated. Furthermore, it is recommended that the prophylaxis is continued until mobility is no longer significantly reduced (generally for five to seven days).
There is some evidence to suggest a lower incidence of PE (approximately 0.01%) in the day surgery population. Thus, total and unquestioning adherence to the NICE guidance may be seen as over-treatment of a low risk group, with the exposure of many patients to an increased bleeding risk. This could be a reason why anecdotal and published evidence suggests that the NICE guidance in its entirety is not being followed in all day surgery units. Meanwhile, the group at the Norfolk and Norwich University Hospital performed root cause analysis on all of their patients who suffered a VTE post day surgery, and identified the only risk factor for VTE in their cohort to be a previous history of VTE, and so they now only target this high risk population.

Counter-arguments to this include that the mechanisms for follow up of day surgery patients are not universally robust, leading to a failure to detect relevant cases. Significantly, much of the data supporting a low risk in this patient group is historical and in recent years the complexity and duration of surgery undertaken in day surgery have increased. This, coupled with a change in day surgery demographics to older patients with greater co-morbidity leads some observers to comment that the current VTE incidence is likely to be much higher. Clearly, more evidence is required in this area.

**VTE prophylaxis in pregnancy**

As there is now awareness that the incidence of VTE is elevated in all three trimesters of pregnancy, the Royal College of Obstetricians and Gynaecologists (RCOG) recommends that VTE assessment and appropriate antenatal thromboprophylaxis should be commenced as early in pregnancy as is practical. Anaesthetists need to ensure that women presenting for termination of pregnancy and evacuation of remnants of conception, as well as delivery, are assessed and given appropriate thromboprophylaxis. Between 2003 and 2008, VTE-related maternal deaths have fallen from 194/100,000 to 0.979/100,000, though VTE is still the third leading cause of direct maternal death accounting for 7% of all maternal deaths. This reduction is widely attributed to the universal recognition amongst healthcare workers of the dangers of VTE in pregnancy and the rigorous application of the national guidelines for risk assessment and prophylaxis.

However, the evidence base for such guidelines is almost exclusively case-control and cohort studies, leading to the grade C or D recommendations for most situations. The level of confidence is reflected in the discrepancy between the various national guidelines available. For example, NICE recommends prophylaxis in the presence of only a single risk factor regardless of whether the patient is antenatal or postnatal. In contrast, the RCOG stratifies women into low, intermediate and high risk categories based on the presence of particularly high risk factors, such as previous VTE, or a combination of several lower risk factors. It also recognises the higher postnatal risk and recommends separate postnatal assessment with a lower threshold for treatment.

The approach of the RCOG, which makes a greater attempt to target prophylaxis towards the most at-risk patients whilst reducing over-treatment in the lower risk patients, is likely to continue to be the predominant policy in the UK, especially considering the fact that its use has coincided with the reduction in mortality from VTE. However, an even greater level of agreement between the RCOG, NICE and others would help remove any ambiguity about which guidance should be followed.

**Implications of oral contraceptives and hormone replacement therapy for VTE prophylaxis**

VTE is one of the most serious complications of the oral contraceptive pill (OCP). Evidence suggests that the rate of VTE in female non-users of reproductive age is approximately...
4–5/10,000, whilst the rate in users of the OCP is in the range of 9–10/10,000 women per year. In comparison, VTE rates in pregnancy approach 29/10,000 overall and may reach 300–400/10,000 in the immediate postpartum period.15

In view of the fact that oestrogen containing contraceptives are a risk factor for VTE, the current NICE advice is that patients should be advised to consider stopping oestrogen-containing oral contraceptives or hormone replacement therapy four weeks before elective surgery, and if stopped, advice should be provided on alternative contraceptive methods.

It should be noted that in the case of HRT this advice is uncontroversial. However, the case of sexually active women being counselled by either the pre-operative assessment staff or surgical staff to stop their oral contraceptive pill and use other forms of contraception is controversial. This is because the RCOG and the Faculty of Sexual and Reproductive Healthcare (FSRH) believe that doctors should be appropriately trained prior to offering advice on family planning and as a minimum standard hold the Diploma of Faculty of Sexual and Reproductive Healthcare (DFSRH). It is unlikely that the majority of anaesthetic, surgical or pre-operative assessment staff will hold the DFSRH. Even with uniformly good contraceptive advice and diligence on the part of the patient there would be an inherent risk of unwanted pregnancy associated with changes to an established contraceptive regimen. Sudden cessation of oral contraception is associated with unplanned pregnancies and morbidity as demonstrated by the ‘pill scare’ of 1995. In October 1995 the UK Committee on Safety of Medicines suggested that some oral contraceptive pills had a higher incidence of VTE. This led to mass hysteria in the British press and to a dramatic and sudden drop in the use of the OCP, which was followed by an increase in the absolute number of surgical abortions and reported maternal deaths from VTE in the UK.16

It is therefore unfortunate that NICE does not consider alternative advice such as continuing the contraceptive pill, but with extended chemical and physical prophylaxis. Obviously, further research is required.

Extended prophylaxis for patients with a previous history of VTE

NICE recommend that for most routine cases VTE prophylaxis be discontinued when full mobility is regained and in most cases it is suggested that this is five to seven days post-operatively. For patients who have had major cancer surgery in the abdomen or pelvis, a hip or knee replacement or a fractured hip fixed, extended prophylaxis of between ten and 35 days is recommended.

However, there is no guidance about extended prophylaxis for particularly high risk patients undergoing lower risk surgery. For example, it is well established that a previous episode of VTE is one of the strongest risk factors but no comment is made in the NICE guidelines about extended prophylaxis for this group. Individual Trusts are therefore left to develop their own policies, perhaps based on local data, but inevitably leading to a non-consistent level of VTE prophylaxis nationally. Clearly, again more evidence is required in this area.

New oral anti-coagulants (NOACs)

In recent years several new oral anti-coagulants have been developed as alternatives to warfarin and heparins and some of them are recommended for VTE prophylaxis in certain circumstance by NICE. These NOACs include dabigatran, rivaroxaban and apixaban. These drugs appear to be attractive as they require no monitoring, no dietary modifications, have minimal drug interactions and are all orally administered. The main concern associated with these agents is the management of bleeding, as there are no known effective antidotes to these agents at present. Another concern is that hospital doctors may not recognise these agents as anti-coagulants and may co-prescribe other anti-coagulants simultaneously.

Conclusions

There can be no doubt that the publication of the NICE guidelines in January 2010 has contributed to an increased awareness of VTE prophylaxis, and that the use of CQUN targets has improved assessment. However, the NICE guidelines cannot be accepted uncritically and further research is required to allow VTE prophylaxis to be fine tuned to the individual patient. In the meantime, anaesthetists, as well as all other healthcare professionals, share an obligation to ensure that they engage fully with risk assessment and appropriate prophylaxis.

References


Hi, I am Ramana Alladi and I am an elected SAS Council member of the College. I feel tremendously privileged to be elected to Council to represent career grade doctors (CGDs) and to be a part of the great organisation. I never imagined that I would ever achieve this in my life.

First of all, I would like to thank Andy Lim and Roger Laishley, the two SAS representatives before me who have made some significant achievements, but I believe that there is still a lot to be done. It is now my turn to build on what they have started. Speaking to the career grade doctors around the country I realise that there are some things that the College can do to help the careers of the career grade doctors.

I noticed that several new CGDs have been appointed to our specialty recently. We have the largest number of CGDs in the NHS and 25% of the anaesthesia workforce are CGDs. Many of them are young with three to five years’ experience and are quite new to the specialty. Some of them are from abroad and are not familiar with the culture of the NHS and our practice of anaesthesia in the UK, especially the ones who have come from the Eastern European countries who can find the language difficult.

These doctors need a proper induction before they commence regular duties. They can do with some opportunities to train and to attend teaching programmes. They need tutors to guide them, as trainees do. Some of them need assistance with preparing for our examinations and need to learn sub-speciality skills and use and perfect them.

It is rather difficult for career grade doctors to find time and opportunities to achieve these within their job plans. Service needs often prevent them from doing so. On the other hand, there are some who have specialist skills and vast experience in some sub-specialties. They would like to have independence and autonomy to practise. It will be useful if there is a mechanism to arrange to accredit them by assessment and certification. It will only inspire them to work harder and enjoy their work. It may be beneficial especially when the NHS is planning to provide greater cover 24/7. This cover could involve senior and experienced CGDs who are accredited.

I realise that CGDs look up to the departments, Trusts, Deaneries and the College for assistance towards education, teaching and training. Over the years, because of their service commitments and being a service grade, this aspect has been ignored or was not taken seriously. Without active training and teaching it is easy for CGDs to have their skills become downgraded or out-dated. Without opportunities to improve themselves it is not possible to progress in their careers. This may not be in the main remit of the College, but the College can influence the appropriate authorities.

It is my intention to establish an educational framework for junior and senior career grade doctors, assisting in providing training, and creating teaching facilities. It is important that all the CGDs have opportunities to learn new skills, improve them and practise them within their job plans. They will need this for revalidation.

Anaesthetics, being a hands-on specialty, is associated with performing procedures: something in which many CGDs have vast practical experience. I believe that their services are not fully utilised in that way. Several CGDs are interested in teaching and training. Mechanisms are available to train them as teachers and trainers, but are often not accessed. It will lessen the burden on consultants.

I believe that one of the ways to achieve this is to have designated tutors or mentors in every department to specifically look after the educational needs of CGDs. As the experience of CGDs is so variable it is important to cater for individual CGDs by establishing personal profiles and individual personal development plans. I appeal to clinical directors to consider this seriously.

You may have noticed that we had no applicants for the election of SAS Council member of the College last year. May I appeal to the fellow CGDs to seriously consider coming forward to and join Council and represent your colleagues, strengthen our voice in Council and fight our cause.
It probably escaped your attention last time when the nominations for election for SAS Council were announced. Please look out for the announcement this time round.

It is a great privilege to be on the Council of such a great organisation and have the opportunity to be a part of the decision making which influences our practice. You get opportunities to network with other highly motivated Council members and notable anaesthetists and learn from them.

It is indeed a huge commitment but is a very worthwhile activity. Finding time to meet these commitments can be difficult. However, in March this year all four Chief Medical Officers of the devolved nations and Sir Bruce Keogh wrote to every employer in the NHS to urge them and their Trust Boards to look favourably on requests from doctors for absence to undertake national work of benefit to healthcare systems across the UK. A copy of the letter and more information are available on the College website at: www.rcoa.ac.uk/node/11410. Discuss this with your Trust and the Clinical Director and maybe re-designing your job plan. I am pretty sure that any member of the Trust and especially your Clinical Director will only be too happy and proud to see one of their colleagues sitting on the College Council, keeping them up to date with the latest developments in the specialty. You can also annualise your contracts, have Council meeting days (Wednesdays) free and work on different days instead. You can swap the lists or do extra lists over the weekend. Every meeting you attend is educational in itself and helps you to improve your practice. I find that all the Council members are very friendly and eager to help in every possible way.

It is time that the career grade doctors as a group showed greater enthusiasm by contributing to their departments, operating theatres and hospitals locally and nationally and make our presence felt. There is so much to do. We should try and get involved more by taking part in the audits, teaching and training, organising meetings and workshops and getting involved in committees. It is time to be active and be interested in things beyond your everyday jobs.

Please do contact me or the College if you have any suggestions you would like to make and ideas you would like us to consider at the College. Please do not hesitate to get in touch if you want to know about the duties of a Council member. I shall be looking forward to hearing from you and meeting you.
As part of the revalidation and quality improvement agendas, there is renewed interest across medicine in collecting patient reported outcome data. As previously discussed in Bulletin articles, patient feedback per se falls into three categories: feedback on communication skills (‘bedside manner’); feedback on the general environment and behavior of staff (patient experience); and finally, feedback on outcome, from the patient point of view (patient-reported outcome). We have previously focused on patient feedback on communication skills; we are now going to focus on patient satisfaction/patient reported outcome.

Patient reported outcome measures – surgery

It was stated in the 2008 report ‘High Quality Care for All’, authored by Lord Darzi, that patient reported outcome measures (PROMs) would soon become a key metric of quality in the NHS. We have seen this approach endorsed by the Department of Health, with the huge investment and interest in the national PROMs programs in orthopaedics, general and vascular surgery. For the past 3 years, all patients attending for unilateral joint replacements, inguinal hernia repairs and varicose vein repairs have been asked to complete ‘Health-Related-Quality-of-Life’ (HRQOL) questionnaires immediately before, and several months after their procedure, in order to determine the ‘health gain’ (or otherwise) achieved by undergoing surgery. For joint replacements and varicose vein surgery, there are disease-specific’ PROMs, which ask the patient questions about symptoms related to the underlying surgical problem (the Oxford hip and knee scores and the Aberdeen Varicose Vein Questionnaire). There are also a number of ‘generic’ PROMs questionnaires, which have been scientifically developed and extensively validated. These include the ‘Short-Form 56′ (SF-56) and the EuroQOL (also known as EQ5D). The latter, which is notable for its brevity, is increasingly used not just in clinical practice but also as an outcome measure in clinical trials. It addresses five domains related to HRQOL: pain, mobility, depression/anxiety, ability to self-care and the ability to undertake ‘usual activities’ (e.g. work, exercise etc.) The surgical procedures which are being assessed in the national PROMs program clearly have something in common: they are aimed at improving quality of life, rather than saving or extending life; therefore they would seem to be perfect procedures for which success can be ‘judged’ using PROMs. Interestingly, initial results demonstrate that particularly in varicose vein and inguinal hernia repair, there are a significant proportion of patients in whom HRQOL is unchanged – or even worse – after their operation. As with all data, the context, and also confounding factors must be considered – for example, there appears to be a sociodemographic gradient in treatment responses. Nevertheless, in surgery, the measurement of patient reported outcome is an expanding industry, and will increasingly be regarded as a key measure of quality.

Patient satisfaction with anaesthesia

So what of patient reported outcome after anaesthesia? It is certainly true that the quality of anaesthesia care will have a lasting impact on the patient, particular in major surgery – for example, evidence based interventions such as detailed risk assessment, goal directed optimisation and high quality analgesic regimens all play their role in preventing perioperative complications. However, clearly the patient’s perioperative course will also depend largely on the quality of the surgical team, both within and without the operating theatre, and the quality of postoperative care. Therefore, when considering the measurement of patient satisfaction with anaesthesia itself, we perhaps should focus predominantly on those elements of the patient’s postoperative outcome which are more directly within our control: for example, relief of ‘anaesthesia-related’ side effects (e.g. postoperative nausea and vomiting) and elements of care which are principally our responsibility (e.g. pain management, temperature control).
Clinical experience tells us that there are lots of departments around the UK which are trying to measure patient satisfaction with anaesthesia, by constructing questionnaires and conducting internal service evaluations/audits. In order to help departments measure patient satisfaction in a scientifically robust manner, the RCoA is issuing evidence-based guidance, which should be published by the time this article reaches you. The guidance is based on a systematic review conducted by researchers at the UCL Surgical Outcomes Research Centre and the NIAA’s Health Services Research Centre. The paper and the guidance highlight the process which is involved in developing a patient satisfaction measure and give some examples of questionnaires which might be used in particular clinical settings (e.g. preoperative assessment clinic, maternity care or paediatrics) or for particular purposes (e.g. quality improvement or research).

Developing a patient satisfaction measure
Designing a questionnaire might seem to be a relatively straightforward task. However there is a clear scientific process involved with questionnaire development and validation, and the quality of the measure (and therefore the reliability of the results) will be affected by how rigorously the questionnaire development process has adhered to these scientific principles. The step-wise psychometric development process involves the generation of questions (including using patients views) pilot testing and re-testing, assessing the construct, face, and criterion validity of the questions and the reliability and acceptability of the questionnaire to users. If this seems like an awful lot of effort to go through, there is good news. There are several well developed and validated instruments in the literature which are able to measure patient satisfaction with anaesthesia in most settings we will come across: e.g. preoperative assessment, or the delivery of perioperative anaesthesia to adults and children; there are also some which have been designed for use in particular types of surgery or anaesthesia (e.g. cardiac surgery, or sedation-based anaesthesia practice). The guidance suggests that departments should evaluate the available validated measures, to see if there is one which suits their purposes, rather than embarking on developing a novel measure, unless a scientific development and validation study is planned.

There are some unanswered questions related to the measurement of patient satisfaction with anaesthesia. Choice of the mode of delivery of the questionnaire (for example paper survey vs electronic survey vs face-to-face or telephone interviews) is a difficult conundrum – an electronic survey would seem to be the most elegant solution, but risks bias if this is conducted post-hospital discharge (many elderly patients may not have internet access). In-hospital electronic surveys using hand-held computers would be an alternative solution, but incurs capital costs. Secondly, when to administer the questionnaire? Patient responses after ambulatory shoulder surgery may be quite different on day 0 (with a beautifully working nerve block and some residual sedation) to day 1 (having woken up at 4:00 am with excruciating pain after the block has worn off).

There are no easy answers to these questions, and a department’s approach to engaging with patient satisfaction measurement may depend on which elements of the service they wish to evaluate. However, the guidance at least provides a platform from which departments might consider starting to take an evidence-based approach to measuring patient reported outcome after anaesthesia. In addition, the RCoA and HSRC plan to promote the importance of measuring patient reported outcome by running a national ‘sprint audit’ measuring patient satisfaction towards the end of 2013. By doing so, we hope to establish the feasibility of systematically assessing patient satisfaction using validated measures, to enable comparative audit and facilitate quality improvement. Details of this, and how your department can participate will be published in the Bulletin and on the website in due course.

References
1 Patient feedback for revalidation. RCoA Bulletin 2013;77:27–28
Since its formation the NIAA has had close links with the Academic Department of Military Anaesthesia and Critical Care (ADMACC). A key ADMACC activity is the education of military anaesthetists. This article outlines the importance of training in the Defence Medical Services and introduces a proposed Level 3 Matrix to aid revalidation and future job planning.

The Defence Medical Services (DMS) have been involved in supporting military operations in Afghanistan for the last 12 years and this has led to many advances in trauma management, particularly around techniques for Damage Control Resuscitation. It is envisaged that the current conflict in Afghanistan will end in 2014 and so it is important now to plan for the future to ensure that the valuable corporate knowledge is not forgotten.

It is envisaged that future conflicts will be small contingency operations with teams at high readiness.

Human factors in Defence anaesthesia
In addition to the technical skills required to deal with major trauma, the most recent conflict in Afghanistan has shown that human factors are paramount to the success of the complex trauma team. Most DMS anaesthetists are embedded in the NHS and so the case mix of blast and ballistic injuries in soldiers with very high injury severity scores is very different from the trauma that they might experience in the UK. It is therefore important that pre-deployment training and continuing professional development (CPD) focus on non-technical skills in addition to new clinical concepts such as near-point testing.

Defence Anaesthesia Level 3 CPD Matrix
The Defence Anaesthesia Military Higher Training Module has been compulsory for DMS anaesthetic trainees for the past three years and consists of modules centring on pre-hospital care, in-hospital resuscitation, field anaesthetics, critical care, battle casualty rehabilitation and deployed military hospital management. In order to maintain an operational capability in times of contingency, it is important that the military anaesthetist consultant works to a job plan to allow them to maintain the skills necessary to deploy. This will also include concentrating CPD activity over the five-year revalidation cycle. Recently a Level 3 Matrix has been proposed to allow DMS anaesthetists a framework to discuss with their appraisers and to ensure that any pre-deployment training is useful and also recognised (Table 1).

Military Operational Surgical Training Course
This course was established in 2009 and has been key pre-deployment training for those assigned to OPERATION HERRICK (Afghanistan). A week is spent at the Royal College of Surgeons with an emphasis on capability-driven, operationally focused team training. To that end, deploying anaesthetists train alongside their general and orthopaedic surgical colleagues, theatre nurses and operating department practitioners practising scenarios in the dissection room and high fidelity simulation suite with the equipment that will be available at Role 3 (Camp Bastion Hospital). Scenarios reflect current practice and also allow the opportunity to develop mental models and discuss contentious issues such as airway management in trauma and the management of a traumatic cardiac arrest.

The course is constantly updated based on evidence from military research and commences with a ‘live link’ to Camp Bastion so that the current operational tempo can be gauged. The course has recently been approved for 20 CPD points from the Royal College of Anaesthetists and so is now essential for revalidation. A screen shot of a typical theatre scenario is shown in Figure 1.

Tri-service Anaesthetic Apparatus High Fidelity Simulation Course
The Tri-service Anaesthetic Apparatus (TSAA) was first described in 1981 and until recently was the main anaesthetic machine for deployed anaesthetists. At present, this is the back-up equipment in Role 3 but could potentially be used for small contingency operations. Without a CE Mark, this draw-over
### Table 1  Proposed Military Anaesthesia Level 3 CPD Matrix

<table>
<thead>
<tr>
<th>General</th>
<th>Pre-hospital</th>
<th>Resuscitation</th>
<th>Military Anaesthesia</th>
<th>Regional Anaesthesia</th>
<th>Field Pain Management</th>
<th>Critical Care</th>
<th>Training</th>
<th>Management</th>
</tr>
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<tbody>
<tr>
<td>Advanced Leadership and Crew Resource Management</td>
<td>Military Pre-Hospital Anaesthesia</td>
<td>Military Resuscitation</td>
<td>Military Anaesthesia for Blast and Ballistic Injuries to the Chest</td>
<td>Regional Anaesthesia for Military Injuries</td>
<td>Field Hospital Anaesthesia Lack</td>
<td>Preparation of Patients for CCAST Evacuation</td>
<td>Awareness of the StR Military Anaesthesia Unit of Training</td>
<td>Familiarity with DMS Structure, Hierarchy and Responsibilities</td>
</tr>
<tr>
<td>Military Clinical Governance</td>
<td>Pre-Hospital Resuscitation Options</td>
<td>Fluid Management for Major Burns with Trauma</td>
<td>Anaesthesia for Blast and Ballistic Injuries to the Head and Neck</td>
<td>Deployed Regional Anaesthesia Equipment Including CPNB Catheters</td>
<td>Field PCA Equipment</td>
<td>Deployable Specialised Medical Assets</td>
<td>Military Appraisal Process During Deployment</td>
<td>Enduring DMS Audit and Data Collection Process</td>
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<tr>
<td>Intra-osseous Devices</td>
<td>Near Patient Coagulation Testing</td>
<td>Anaesthesia for Blast and Ballistic Injuries to the Abdomen</td>
<td>DMS Regional Anaesthesia Protocols and Documentation</td>
<td>Early Prophylaxis of Neuropathic Pain</td>
<td>Management of Blast Lung</td>
<td>Risks of PTSD and Decompression Processes</td>
<td>Aeromedical Evacuation Chain and Movement Processes</td>
<td>Role of the Deployed Medical Director</td>
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<td>Control of Catastrophic Haemorrhage</td>
<td>Concepts of Vascular Access and Rapid Infusion Devices</td>
<td>Deployed Anaesthetic Apparatus</td>
<td>Working Knowledge of Sona-anatomy</td>
<td>Analgesia for Aeromedical Evacuation</td>
<td>Specific Deployed ICM Equipment</td>
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<td>Casualty Reporting Systems</td>
<td>Ketamine for Military Anaesthesia</td>
<td>Paediatric Adaptations of Deployed Apparatus</td>
<td>Use of Regional Blocks During Transfer</td>
<td>Role 4 Analgesia Protocols</td>
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<td></td>
<td>Management of Military Airway Injuries</td>
<td>Deployed Theatre and Transfer Ventilators</td>
<td>Pain Management During Rehabilitation</td>
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<td>Broselow Bags and Paediatric Skills Relevant to Resuscitation</td>
<td>Deployed Indirect Laryngoscopy Devices</td>
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<td></td>
<td>Overview of Initial Management of Pelvic Injuries</td>
<td>Anaesthesia for Severe Burns</td>
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<td></td>
<td>Management of Traumatic Cardiac Arrest</td>
<td>Anaesthesia for Head Injuries in the Military Setting</td>
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<td></td>
<td>Overview of Anaesthetic Management at Role 4</td>
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anaesthetic apparatus is not available for use in routine NHS practice, and so the opportunity must exist for practice prior to deployment.

Currently, this course is run at the Centre for Simulation and Patient Safety in Liverpool as a one-day course and utilises the SimMan 3G wireless manikin (Laerdal, Orpington, Kent). Anaesthetic and ODP candidates form a small team as part of a contingency operation in a local medical facility and actors play the roles of the surgeons and nurses. This allows scenarios to be manipulated so that the TSAA is assembled and then troubleshooting can take place around critical incidents. The scenarios are videoed so that an immediate human factors focused debrief can occur immediately afterwards. This course also has 5 CPD points from the RCoA.

Hospital exercise
A deploying hospital unit will undertake training on the hospital exercise at the Army Medical Services Training Centre in York. This is a macro-simulation that practises all the systems and processes required by the deploying team in a replica of the Role 3 Hospital in Camp Bastion. Simulated actors and manikins are used to run a real time exercise from pre-hospital care on the ‘Chinook Helicopter Simulator’ to transfer into the emergency department and then transfer around the hospital to theatres, critical care and the medical wards. In the future it is hoped to use this model to practise smaller deploying units such as Role 2 Afloat (a surgical team on a maritime platform) or the VHR (very high readiness) capability.

Conclusion
It is important that a process is in place to allow DMS anaesthetists to demonstrate that they are capable of deploying at high readiness in peacetime and be in a position to undertake damage control resuscitation on seriously ill casualties. It is hoped that the proposed Level 3 Military Matrix will provide a framework for training and revalidation.

References
1 Afghan mission into final phases, says David Cameron. BBC News, 14 March 2013 (www.bbc.co.uk/news/uk-politics-17362444).
Most of you will be aware of the Shape of Training Review which will make recommendations on the future training of healthcare professionals in the NHS. On behalf of the FPM, Kate Grady submitted a detailed analysis of important issues with respect to the training of pain medicine specialists. We acknowledged that pain is often best managed in the community setting but emphasised that patients with complex problems should be managed by appropriately trained specialists (either in the community or in hospitals). We are the only doctors in the UK specifically trained in pain medicine undertaking pain specific revalidation and CPD. It is likely that this report will have a significant influence on future training and healthcare workforce. We await its final conclusions with interest.

Our Professional Standards Committee continues to make significant contributions to the work of the FPM and standards of care in pain medicine. Recently, we have made significant changes to its membership; Karen Simpson continues as chair and we are pleased to welcome Drs Weiss, Wilkinson, Davies, Searle and Balasubramanian as new members. The committee is also responsible for our communication strategy and education programme. Currently, it is working on the provision of patient information for patients with pain, starting with the use of medication.

The spring edition of the Faculty’s journal *Transmitter* has been available on our website for a few weeks now. It is an excellent read for those interested in the work of the FPM and I heartily recommend it. As well as accounts of the ongoing work of our committees, this issue includes an article on neuropathic pain in patients with cancer, review of pain medicine in Wales, discussion on commissioning for specialist pain services and progress reports on the e-learning for pain program and British Pain Society/Dr Foster National Pain Audit. We are a principal stakeholder in the latter which is chaired by Stephen Ward who is an FPM Board member. The data have shown an increase in the quality of life and reduction in healthcare resource utilisation in patients attending pain clinics. However, consistent with previous audits, there is still a wide variation in the availability and nature of pain services. Detailed information is available on the website (www.nationalpainaudit.org). The audit team are to be congratulated in acquiring further funding from Healthcare Quality Improvement Partnership (HQIP) in order to collect further data from patients identified in the original audit.

The Faculty continues to provide an excellent educational programme led by Sanjeeva Gupta who is our Educational Meetings Advisor assisted by Drs Kothari and Balasubramanian. The June study day dealt with opioids in persistent non-cancer pain and there was an examination tutorial day on 7 June. We are currently organising the Annual Meeting of the FPM; this will be on 22 November 2013. More details will be available on the website soon.

It was a great pleasure to meet many of our advanced pain trainees at the BPS AGM recently. Their enthusiasm and commitment to pain medicine are very impressive and I am convinced that we are training a new generation of pain specialists who will make a step change in the quality of care for patients with complex pain problems.
Collaborating for quality: a national strategy for intensive care in the UK

The Faculty of Intensive Care Medicine

Professor J Bion and Professor T Evans
Dean and Vice-Dean, Faculty of Intensive Care Medicine

The creation of the Faculty of Intensive Care Medicine in 2010 and the establishment of ICM as a primary specialty in 2011 were game-changing events. They mark the point at which ICM changed from an organically evolving discipline to one in which the specialty has to take direct responsibility for its future, and for improving patient care. Whether one takes a Thatcherite or a Hobbesian position on social organisation, ‘taking responsibility’ cannot be achieved without co-operation between the various professional bodies in critical care which have appeared over the last 40 years. There are 16 such organisations (Table 1), with varying degrees of overlap and repetition of effort, but no common strategy. This is a significant weakness at a time when the government is proceeding at breakneck speed with the reorganisation of both the health service and the whole of healthcare education. Strong professional leadership and common purpose are required now to ensure that the commissioning process is located within a quality continuum which includes performance management, quality assurance, quality improvement, peer review, lifelong learning, professional development, and research. This continuum is not the sole province of any one group, nor is it achievable without co-operative professional effort.

The first national strategy (in all but name) for intensive care was Comprehensive Critical Care,\(^1\) written by a multiprofessional group supported by the Department of Health. The report’s wide-ranging recommendations established the foundations for improvements in intensive care for the next decade, and resulted in visible improvements in resources, staffing, research activities, case mix data acquisition, and above all in patient outcomes.\(^2\) Last year the Faculty undertook a review of the current position of intensive care, and in conjunction with partner organisations (Table 1) invited Professor Sir John Temple to chair a commission of enquiry into the current disposition and ambitions of these groups with a view to creating a foundation on which to build a renewed national strategy. Sir John invited two other commissioners to join him, Dr Judith Hulf and Professor Jon Cohen. Following a plenary meeting between all participants, the Commissioners took evidence from each organisation. Their report ‘Collaborating for Quality in Intensive Care (CiQ)’ was published on 21 March 2013.\(^3\) Formal responses have followed from the FICM,\(^4\) the RCN-CC&IFF, the GMC, and ICNARC. A partnership teleconference was then held on 9 April.

CiQ was welcomed by the great majority of participants to the process. The Commissioners’ main recommendations are described below together with the actions taken to date (5 May).

1. **A Stakeholder’s Forum for ICM should be re-established:** We have agreement between participants that we should establish a Critical Care Leadership Forum representing the participants to CiQ, and linking professional bodies to the NHS Commissioning structures (Figure 1).

2. **The Royal College of Paediatrics and Child Health should become the 8th FICM Trustee College:** Discussions are now taking place between the lead College and the RCPCH on this proposal, which has been welcomed by the Faculty. The Paediatric Intensive Care Society has accepted an invitation to join the Faculty Board in an ex officio capacity.

3. **Collaboration with nursing needs underpinning:** The Faculty is co-ordinating a meeting on 16 July between the various nursing organisations to determine how best to implement, quality assure, and support a national competency-based training programme for critical care nursing, based on the excellent work done by the National Nurse Leads Forum.\(^5\) Options which we are considering include Faculty...
affiliates of the Royal College of Nursing so that we can create a Critical Care Nursing Forum to work in parallel with the Faculty’s physician training programme. This will also allow harmonisation with the new Advanced Critical Care Practitioner programme, the first meeting of which will take place on 19 June.³

4 Improved audit and research collaboration is necessary: The Commissioners have made two key recommendations under this heading:

   a. First, that we should develop a research federation to optimise research outputs and link audit and research more effectively. A well-known model is offered by the ANZICS Clinical Trials Group.⁷

   b. The second recommendation is to improve access to, and sharing of data from, the ICNARC Case Mix Programme. These recommendations were supported by all organisations participating in the teleconference call of 9 April. The Faculty has proposed that the Case Mix Programme comes under new governance arrangements with trusteeship through the Critical Care Leadership Forum, financial support being offered where required through the participating organisations, and governance through the Faculty (and hence royal colleges, as is the case for the RCoA’s Health Services Research Centre). Alternatively, governance could be offered through a university, as is the case for NICOR (the National Institute for Cardiovascular Outcomes Research)⁶ and the Paediatric Intensive Care Audit Network (PICANet).⁹ We will meet with ICNARC to explore these and other options.

5 Relationships between other professional bodies and the Faculty: The Commissioners have proposed greater clarity of roles between the FICM and the Intensive Care Society, closer integration of the various national societies for ICM, and strengthened links with the Centre for Defence Medicine. The Faculty has already acted on these proposals. The Centre for Defence Medicine has been represented in the Faculty Board and the Regional Advisors since inception.

   What next? The first step in turning CIQ into strategy and from strategy to action is to convene the initial meeting of the Critical Care Leadership Forum. This will take place on 16 July to determine terms of reference and the process for electing a chair, and then to sketch out strategic objectives for the next five to ten years. It is likely that these will include:

   ■ Standards for intensive care: The Faculty and ICS are already working with partner organisations to develop a comprehensive set of quality standards (‘Guidance on the Provision of Intensive Care Services’, emulating the RCoAs approach) which can then be used for diverse purposes from commissioning to research.

   ■ Workforce planning: The demand for intensive care services and specialist clinical staff will increase. So will the need for trainees to fill those posts, and the desire of trainees to apply for them. We need to be able to anticipate ‘push’ and ‘pull’ factors ahead of time. We are working with the Centre for Workforce Intelligence to develop workforce models, and we will commission the Royal College of Physicians to manage the Faculty’s workforce database.

   ■ Multidisciplinary training and practice: ICM was the first specialty to create a competency programme (CoBaTrICE) which provided a platform for non-physician training as well. In addition to competency-mapping between countries and between medical disciplines, it has already formed the basis for training Advanced Critical Care Practitioners in the UK, and we will also link it to the new nursing competency framework as well. ICUs will become places in which practitioners from varied backgrounds can provide complementary and overlapping skills to optimise patient care.

   ■ Service reconfiguration: In addition to hospital mergers and changes in the disposition of acute services, the NHS Medical Directorate is promoting seven-day working, the Academy of Medical Royal Colleges has developed standards for seven-day consultant-led care, and the Royal College of Physicians has established the Future Hospital Commission to propose new models for acute care delivery. Intensive care plays a central role in facilitating these developments through multidisciplinary clinical practice.

   ■ Audit, research and quality improvement: We need to develop new models for collecting, analysing and acting on performance and research data in order to improve patient care through training, professional development and reliable bedside practice. For example, new knowledge gained through research or analysis of the Case Mix Programme should be incorporated in professional standards and in training programmes with minimal delay. Barriers to change might be diminished if the professions were directly responsible for the Case Mix Programme as a central part of their business.
The Francis Report into Mid Staffordshire Hospital and the Leeds paediatric cardiac surgery debacle have each demonstrated the troubled relationship between performance measurement, performance management, access to data, and professional leadership and responsibility. By contrast, Collaborating for Quality has provided the intensive care community with an opportunity to create an integrated multiprofessional approach to quality improvement through the synergies of creative collaboration. We should take this route while it is available to us.

References
5 www.cc3n.org.uk/#/competency-framework/4573335411.  
8 www.ucl.ac.uk/nicor.  
9 www.picanet.org.uk.

Table 1
Professional Organisations involved in Intensive Care in the UK
- Faculty of Intensive Care Medicine (FICM)
- RCoA lead college for seven Trustee Royal Colleges
- Royal College of Paediatrics and Child Health (RCPCH)
- Royal College of Nursing Critical Care and In-Flight Forum (RCN-CC&IFF)
- Intensive Care Society (ICS)
- Paediatric Intensive Care Society (PICS)
- Scottish Intensive Care Society (SICS)
- Welsh Intensive Care Society (WICS)
- Northern Ireland representation
- British Association for Critical Care Nursing (BACCN)
- Defence Medical Services representation
- Critical Care Networks (CCNs) National Nurse Leads Forum (CC3N)
- National Outreach Forum (NOrF)
- Intensive Care National Audit and Research Centre (ICNARC)
- NIHR-CRN-Specialty Group for Critical Care (SG-CC)
- UK Critical Care Research Forum

Figure 1
Post-Collaborating for Quality: Proposed Structure for National ICM Representation

- National Clinical Director for specialised services
- Programme Boards: Trauma (Adult ICM) - Women & Children (PICM) - NHS Outcomes Framework 3
- Critical Care Leadership Forum
- Administrative support and governance via FICM & Trustee Colleges
- Collaborating For Quality Implementation & National Coordination Body
- Faculty of Intensive Care Medicine (7 Royal Colleges) + Paediatric ICM (RCPaedeChild Health)
- Professional Societies: Intensive Care Society, Paediatric ICS, Welsh ICS, Scottish ICS, Northern Ireland ICS

- Nursing Organisations, Networks: RCN Critical Care & In Flight Forum, British Asian Critical Care Nurses, National Outreach Forum, Critical Care Networks & CC3N

- Data & Audit: Intensive Care National Audit & Research Centre Case Mix Program, Scottish Intensive Care Society, Audit Group, FICM, PICANET, ICGQP (INCAPHE)

- Research: ICS Foundation; ICNARC; GTU, National Institute for Health Research Critical Care Specialty Group; UK-CCRIP

- Members, Fellows, Patients, regional professional networks

- Regional Medical Directors
- Area Team Specialised Services
- CDGs, Senators, HAWEBS, MCSes
- TRUSTS
The Francis Inquiry emphasises the need for accurate, real-time local monitoring of quality of care, if any risk of harm is to be rapidly detected. The effective use of quality indicators within perioperative care, however, holds the potential for a broad range of benefits at both local and national service levels.

Implementing robust processes for collecting and reporting data against key structure, process and outcome parameters, provides the basis for a quantitative understanding of variations in care. At the local level, better use of metrics, including intelligent monitoring and feedback to clinicians and clinical departments, provides a window on the performance of the local clinical system and a platform for continuous quality improvement. At the national level, the possibility exists to harness the power of large datasets to learn from experience across many individual units, to analyse what may be relatively infrequent events, to establish commonly agreed national standards and to tune guidance for safer, better quality care.

With an agenda to develop guidance for support of a national programme of quality measures, the NIAA’s Health Services Research Centre (HSRC) has recently undertaken a national survey of the use of quality indicators in perioperative units. Data were collected in the November 2012 – February 2013 period and we are most grateful to the 173 clinical directors and respondents who returned data for their units. This encouraging response rate is no doubt indicative of professional interest in this agenda, and means that we have been able to develop a valuable dataset which includes summary and qualitative data concerning local quality monitoring practices at over 140 perioperative sites. The results from the survey are being fed into the activities of the HSRC Quality Measures Working Group, tasked with developing a framework and guidance for perioperative quality measures.

The primary aim of the survey was to identify which perioperative quality measures and indicators are being routinely used and in which contexts. Specifically, the survey was designed to determine the frequency of local reporting of data for a range of established indicators, including those related to perioperative outcomes, patient risk, critical incidents, patient experience, periop processes, quality of recovery and service efficiency, amongst others. An important feature of the questions is that they focused not only upon what data were being collected, but how those data were used. Preliminary analysis of survey data suggests that patient reported outcome and satisfaction indicators are only routinely monitored in a minority of units and that mortality, incident and productivity data are most frequently monitored. Implementing and sustaining quality monitoring programmes are resource intensive and likely to be dependent upon a range of local enabling factors, such as the availability of electronic data administration systems. Specific metrics may vary in their relevance to different end-user groups. Many of the established perioperative outcome measures may be of limited sensitivity or specificity for quality of anaesthesia, for example. It is therefore important that we understand how quality indicators are being used locally, in order to learn from and spread examples of best practice.

The full results from analysis of the survey data will be communicated later in 2013, as part of the HSRC Quality Measures Working Group programme. If you are involved in a perioperative quality monitoring initiative and/or feel that you could make a contribution to the development of this programme, then please contact the Health Services Research Centre at www.niaa-hsrc.org.uk/HSRC_contact.
‘Authority is a necessary evil, and every bit as evil as it is necessary’

[UUNMAN, WITTERING AND ZIGO’, GILES COOPER, 1958]

Try substituting ‘whistle blowing’ for ‘authority’ in the above quotation. I shall argue in this piece that the political and media obsessed national climate in 2013 has created a dangerous entity which militates against true reform of the attitudes, lack of accountability and universal quality of care which has led to recent scandals in hospitals and care homes.

Whistle blowing (I cannot bring myself to say ‘whistleblowing’) has become ‘the flavour of the month’. Now words matter and there is a tendency to make, through constant and inaccurate use, what was in the first place a metaphor a ‘thing in itself’, a process, or a proper way of doing things. Take ‘failing schools’ as an example: within ten years of its first use the public has come to accept that there are such things, although most schools which ‘fail’ an inspection have strengths as well as weaknesses, and in any case inspections do not compare like with like. Worse, the term ‘failing schools’ has moved on – even such respectable publications as The Spectator (alas that my maiden name is Addison!) now regularly declare that ‘the school system is failing our children’, adducing no evidence whatsoever. This demonstrates an appalling lack of intellectual rigour, where politically motivated enthusiasm triumphs over rational and logical thought. False premises can generate nothing but false conclusions.

The false premise in encouraging whistle blowing is that to do so will ‘sort things out’. It won’t. What whistle blowing is encouraging is not accountability but the avoidance of accountability. The whole concept has a grubby feeling to it.

**Due process and integrity**

I am a great believer in due process and having systems in place for knowing what is going on within an institution and for dealing with underperformance in any aspect of its core purpose. Hospitals are enormous institutions and it would be stupid to assume that the CEOs can possibly know what is going on at every level. But they still remain responsible for whatever happens within it because they have delegated part of their responsibilities to someone else, who in turn has delegated down. It is therefore in their interest, and the interests of those in charge of a section of the work as well as in the provision of good care, to have robust systems in place to ensure that concerns, competency issues, poor performance and breaches of discipline are not only reported but acted upon at the appropriate level.

Good employment practice depends on the professional integrity, moral courage and leadership skills of everyone in charge and their ability to carry out the proper processes (which the institution must have) for complaints, professional concerns, dealing with inadequate performance or any disciplinary issues down to the level of failing to carry out instructions or agreed procedures. When I say ‘in charge’ I mean whatever you are in charge of, whether an anaesthetic department, your surgical list or personally serving meals on a ward. The ‘come on, old chap’ approach went out with the Charleston. No sensible union will attempt to support a member who has failed to carry out agreed procedures, by the way; they will help them through the problem but they can not support what they have done. I know from experience that some unions will try it on but the fact remains. Do your homework and assess the facts before acting.

**Reporting or tale telling?**

The other problem with whistle blowers is to whom the whistle is blown. Due process within employment law implies that you go first to your immediate superior, then if the matter is not dealt with, one up, another up and so on. If you, as the leader of a section of the institution, have created a climate of confidence in those who report to you there...
is no difficulty. They will come to you when a problem occurs or when they believe that improvements in practice can be made. If you haven’t, they won’t, and therein lies the difficulty. What people need is not to be loved by senior colleagues but to be taken seriously. And do not expect to be loved for doing your job; that is what you are paid for, particularly at the top of any profession.

Let’s be clear about bullying, too. You cannot argue bullying if you are told off, firmly and politely, on a single occasion, for not doing your job properly. If due process is carried out rigorously, whistle blowing would be a very, very, rare occurrence and things would have gone very wrong indeed.

In fact, it seems that the whistle is blown in the public domain and often leaked to the media who can rely, if necessary, on the old defence of protecting their sources. It is far from certain that the press always gets it right. Sometimes, too, the whistle is blown after leaving the institution with a large financial package. Such people are not heroes; they would be, perchance, if they had gone down, with all flags flying, from their posts of responsibility but not when they have nothing left to lose.

The patient place
Where does all this leave patients? Basically, in the lurch. It would be no comfort to me if I or someone dear to me suffered humiliation and distress or died when in hospital or a care home to know that Newsnight or Panorama was running (rather smugly, all things considered) a programme on the horrors experienced. It is far, far too late when a whistle is blown. It is rather like the odd business of appointing an end to hostilities in war on an elegant date like the 11th of the 11th – what about the ‘poor bloody infantry’ who continued to die in the intervening days or weeks while the politicians and generals toasted each other on their cunning plan?

As well as proper procedures for ‘health professionals’, the definition of which escapes me, there should be similar procedures for patients and their relatives and friends. At the ‘top’ of this procedure there should be real patients; not the small who would be great, the gong and remuneration-by-quango hunting Mafia or the social media and Twitter obsessed, vested interest brigade, but lay people with the confidence and objectivity to state a case, having considered the facts if facts there be. This body of patients needs direct and frequent access to the CEO and selected senior clinicians and be authorised to visit wards and care homes without prior warning. They need training in what to look for and understanding of the roles played by everyone working in the institution. They need to talk to patients and to remember that even in the Francis Report on Mid Staffs, there were patients who praised the care they had received. A balanced view and the application of the mind are essential.

You will have gathered that I view whistle blowing, as a procedure to be encouraged, with grave disquiet. The solution to bringing all patient care and safety up to the level of the best lies not in telling tales and stirring up media frenzy. It lies in insisting on professional behaviour written on the hearts and imprinted on the minds of every practitioner: on the ward from the surgeon and the anaesthetist to the frightened, vulnerable or confused, nervous patient. Everyone, particularly the frightened, vulnerable or confused, deserves to be treated thus, not with sentiment but with agape – the love which must be applied to all, simply because they are human. To return to Joseph Addison:

‘Content thyself to be obscurely good. When vice prevails, and impious men bear sway,
The post of honour is a private station.’
‘Cato’ (Act IV, Sc 4)

Personal honour is an unfashionable concept these days. But we need it, for it stands above all else in the way we conduct our lives and our responsibilities. If, and only if, each individual involved in patient care does so to the highest standards in their power, and remembers that they are dealing with their fellow humans at what may be the most vulnerable point in their lives, will things be better for all. Whistle blowing has become necessary because some people are not behaving professionally. It is evil because it diverts us from the proper processes of accountability. If we all behaved honourably and dealt with what is wrong at the point of it going wrong, whistle blowers could... well... whistle.

And those poor substitutes for honour, targets, checklist-ticking, whinging about excess administration and ‘the pressure of the job’ and even CQUINs, can go hang.
Although the RCoA is not the first to introduce aspects of specialty accreditation, we believe that we have taken the process to a new and more comprehensive level. The history of the process has been documented in a previous article, but the project has now reached a point where it can leave the pilot stage and become a fully fledged part of anaesthesia healthcare in the UK.

To recap briefly, the College spent the early part of 2011 engaging stakeholders in a project enabling anaesthetic departments to undergo voluntary peer review and assisted quality improvement in order to reach accreditation by the College (Figure 1). Departments assess themselves in a benchmarking process against quality standards set by the Quality Management of Service Committee (QMSC), a subset of the Professional Standards Committee of the RCoA. The standards that have been developed are based upon the document entitled Guidelines for the Provision of Anaesthetic Services (GPAS), which has been completely revised during the winter of 2012, and which is available in electronic format only on the College website. This multi-author document has been written by experts in the content of each chapter, and is fully referenced to national guidelines and recommendations. Furthermore, it has been reviewed by the specialist societies as well as being opened to consultation to all RCoA Fellows and members over the last few months. The QMSC would like to thank the many anaesthetists who made comments and suggestions, all of which were considered with many adopted. It will be revised each year, taking into account any new national guidelines and recommendations that affect the specialty.

The whole project has been carefully developed using a number of pilot sites from all four nations of the UK, each of whom kindly agreed to act as a testing ground during two phases, with the aim of ironing out any problems with the logistics (Table 1). The QMSC is very grateful for the extensive time and effort spent by these departments, especially the hospitality extended by the nine who participated in the second phase, each of which the College attended for a review day.

<table>
<thead>
<tr>
<th>List of participants in the pilot</th>
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<tbody>
<tr>
<td><strong>The Anaesthesia Clinical Services Accreditation Pilot Sites</strong></td>
</tr>
<tr>
<td>Aberdeen Royal Infirmary</td>
</tr>
<tr>
<td>Barnsley Hospital NHS Foundation Trust</td>
</tr>
<tr>
<td>Bristol Royal Infirmary</td>
</tr>
<tr>
<td>East and North Herts NHS Trust</td>
</tr>
<tr>
<td>Epsom and St Helier University Hospital Trust</td>
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<tr>
<td>Guy’s and St Thomas’ NHS Foundation Trust</td>
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<tr>
<td>Pennine Acute Trust (Royal Oldham Hospital)</td>
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<tr>
<td>Plymouth Hospitals NHS Trust</td>
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<tr>
<td>Royal Berkshire NHS Foundation Trust</td>
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<tr>
<td>Royal United Hospital, Bath</td>
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<tr>
<td>Royal Victoria Hospital, Belfast</td>
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<tr>
<td>Southampton University Hospitals Trust</td>
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<td>South Tees Hospitals NHS Trust</td>
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<td>St George’s Healthcare NHS Trust</td>
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<td>University Hospital of North Staffordshire</td>
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<tr>
<td>University Hospital of Wales, Cardiff</td>
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<td>Ysbyty Gwynedd, Bangor</td>
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The process

At the present time, 165 standards have been written, prioritised as essential, recommended or aspirational, and published on the College website together with the evidence required to demonstrate compliance. Initially, departments can view these to see how close they are to meeting all of those marked as essential. When a department feels ready to engage with the process, they can contact the College and register an interest. The timeline is summarised in Figure 1. Once an interest has been registered, a binding agreement will be entered into for four years with a typical subscription of £2,500 per annum, leading to accreditation at some point during that time, and then lasting from the point of accreditation for four years. The department must then reaccredit on a rolling programme in subsequent four-yearly blocks. Initially, the process is conducted online, with completion of a form stating which standards are met or remain unmet. Clearly, there is little point in a department engaging until they have done as much work as they can to meet the standards locally. The point at which they feel they will only be able to meet the standards that are unmet with help and backing from the College is the point at which most will choose to enter the scheme. The College will attend the department by invitation to conduct a gap analysis and confirm which standards are met, and to discuss those that are unmet. The team will consist of two clinical anaesthetists in practice, together with a lay attendee from the College’s Patient Liaison Group (PLG) to represent the interests of patients, and a College administrator to assess overall compliance and manage the visit. All will have been trained in the process (see below). The process is a partnership between the department and the College designed to close the gap and award accreditation, and the time required will vary between departments. Although an assessment of training is NOT part of the remit or review, it is intended that trainees

Figure 1
Timeline for the process as a flow chart:

1. Whole department involved in a decision to engage with ACSA
2. Contact ACSA team to commence engagement
3. Submit self-assessment against ACSA standards using interactive PDF
4. ACSA team offer assistance to meet unmet standards by carrying out on-site review and giving access to the good practice library
5. Department considers and implements recommendations
6. 100% compliance with ‘Priority 1’ standards is reached and tested during an ACSA review
7. Department is awarded accreditation mark for four years
8. Department continuously reviews GPAS and ACSA standards and is supported by the ACSA team to maintain quality
9. Process continues with reaccreditation every four years
Already, considerable interest has been generated amongst clinical directors, regional advisers and College tutors

has made it clear that the process must be self-sustaining after an initial period of considerable financial support from the College.

What’s in it for departments?
Why bother with all of this, and why spend money on it?
Firstly, it is a benchmarking process that allows clinical directors and managers to compare their service with national standards, and this has not been done in anaesthesia before. However, it is important that all members of the department understand the process and are engaged with it. The whole department should meet together to plan the process and ‘buy into it’. This gives the department an initial focus, and several pilot sites reported that just this alone had been beneficial in promoting team working with a common strategic approach.

Secondly, unlike the work undertaken by the Care Quality Commission (CQC) and similar organisations across the UK, this process is one of peer review, undertaken by senior doctors from within the specialty who know what to look for in service delivery, and how to uncover problems that help in root cause analysis, thereby enabling improvement. An accredited department will be one that delivers excellent healthcare to standards set by the Royal College, something to which any clinical director (and, indeed hospital governance board) would surely wish to aspire.

Thirdly, it is a sign to the stakeholders that the department, and hospital, have quality embedded in their approach. The CQC has stated that it regards accredited departments as low risk, which should be of great interest to chief executives!

Fourthly, some directors of education have already indicated that they would...
only wish trainees within a school of anaesthesia to rotate to accredited hospitals once there is enough choice. Generally speaking, hospitals that deliver a high quality service also deliver high quality training.

Lastly, even the small number of hospitals in the second phase pilot demonstrated that there appear to be standards which, although considered essential, are unmet in nearly every department that has taken part so far. This suggests that many hospitals have the same difficulty in delivering certain aspects of high quality care, possibly for the same underlying reasons. However, one or two hospitals may have managed to overcome the obstacle with innovation from which others can benefit, and this enables the College to help departments to meet standards by sharing best practice from other sites. This, of course, keeps the whole specialty together at a time when the NHS appears to be fragmenting into sites. This, of course, keeps the whole specialty together at a time when the NHS appears to be fragmenting into a service that lacks co-ordination. The standards have patient safety and care as the central feature throughout, and the PLG of the College has been involved at every point of development to hone this focus.

The bar has been set at a high level and, as an outward demonstration of this adherence to high standards, an accredited department will be entitled to display a plaque awarded by the Royal College, and to add the accreditation mark to their stationery for the four-year period (Figure 2).

What’s in it for the College?
For some time, the Royal College of Anaesthetists (in common with other medical colleges) has been concerned about its lack of contact with departments. Dr Mike Nevin has done much to put the College in touch with clinical directors through the recently formed clinical directors’ forum, but numerous threats to our specialty are evident, both financial and organisational, and the ability to deliver quality anaesthesia becomes ever more challenging. As stated above, keeping the specialty together with common goals and objectives is essential, especially because the ‘N’ and ‘S’ is being eroded rapidly from the term ‘NHS’, as it breaks into local business units. This co-ordinated approach to healthcare by peer review from within our specialty will do much to protect our future. This is not to say that we do not deliver excellent patient care from within our specialty—generally we do, and developing a ‘good practice library’ for sharing between departments will be a huge benefit for all.

However, this project will also allow the identification of national trends away from the ideal, and give the College leverage to bring problems to the attention of the clinical commissioning groups and the Departments of Health, using an evidence base that will underpin any request for change. This will allow the specialty to develop in the way that the profession wants it to. After all, who can possibly be in a better position to judge that direction than anaesthetists themselves? There is a recent perception that the colleges need to be much more involved, and this puts our College at the forefront of developments.

Training the workforce
Three training days for reviewers have been arranged, and two will have taken place by the time that you read this, with one further planned for October 2013. Training people to review evidence for evaluating compliance, the ability to work openly with departments and in a non-judgemental way, and to make sensible recommendations from which the department can work, all take time and effort, not least in finding appropriate trainers. Sixty reviewers will be trained in the first year, with more following subsequently. Reviewers have been drawn mainly from adverts that appeared over the winter months in the Bulletin, and which generated much interest.

The future
Although the project is now in a position to be launched, it is by no means the finished article and, indeed, probably never will be—it is based on a cycle of continuous improvement. At present, the standards developed are those applicable to the general hospital, and do not include sub-specialties. Although paediatrics and obstetrics are included because they apply to district general hospitals, anaesthetic services for cardiac surgery, neurosurgery, burns and plastics, head and neck, specialist ophthalmic, specialist paediatrics and vascular etc, will comprise a further phase of development, and it is planned that the specialist societies will be key partners in this work. Standards for intensive care and pain medicine will sit with the two faculties. Another likely aspect will be the development of 360-degree feedback from disciplines that use the services of the anaesthetics department—after all, there is no one like a customer to assess whether one is doing a good job! Ultimately, the whole project will comprise an all-encompassing programme with the potential to drive the largest improvement in anaesthetic care in the history of the specialty.

Neither will the project be restricted to NHS departments. Already, interest has been expressed from the independent sector providers, each of whom would like to out manoeuvre their competitors in front of the private medical insurers.

And finally
Already, considerable interest has been generated amongst clinical directors, regional advisers and College tutors, with several departments lining up to officially register immediately after the launch. The College estimates that between ten and 20 departments may register in the first year as a minimum, but also hopes that ACSA will quite quickly become the norm for quality benchmarking in the UK, and that most departments will wish eventually to sign up to become accredited.
This project is the culmination of an enormous effort by many individuals, as well as the staff at the Royal College, departments and specialist groups. The Association of Paediatric Anaesthetists has been particularly helpful in attending face to face meetings to give advice about the standards relevant to their specialty.

More information, including the process for registration, is available on the College website, or from the ACSA team (ACSA@rcoa.ac.uk 020 7092 1574).

References
3 Anaesthesia Clinical Services Accreditation (ACSA) (www.rcoa.ac.uk/acsa).
Improvement science in anaesthesia

The Francis Report of the Mid Staffordshire NHS Foundation Trust public inquiry reminded us all that people must come before numbers and it is the individual experiences that lie behind statistics, benchmarks and action plans that really matter.1 This burning platform in addition to the other challenges facing the NHS, namely times of austerity and an increasing age of the population, means that new ways of thinking are needed. Rather than concentrating on just new drugs or technologies, we need to concentrate on the fidelity of healthcare, that is, improving systems to ensure the delivery of care to all patients in need.2

This new way of thinking is Healthcare Improvement Science or Quality Improvement. Paul Batalden from the Dartmouth Institute defines Quality Improvement as the combined and unceasing efforts of everyone to make changes that will lead to better patient outcome (Health), better system performance (Care), and better professional development (Learning).3

Improvement science has a crucial role to play in benefitting individual patients and developing reliable health systems by bridging the worlds of academia and health service delivery. There has been an inability to reliably embed evidence-based medicine into practice.4 Improvement science is based on scientific principles and provides a mechanism to drive continuous improvement in the quality and efficiency of care.5 As anaesthetists we are in a unique position, due to the multidisciplinary nature of our roles across the hospital, to lead improvement projects and develop into ‘improvement scientists’.

Over the past two decades there has been considerable focus by clinicians on the delivery of evidence-based medicine. This depends on the translation of clinician knowledge into care and the adherence to up to date guidelines. The belief that medical care will be of the highest standard simply because a clinician is highly intelligent, up to date and motivated is no longer reality. Evidence has shown that there is a gap between what clinicians should do and what actually happens in practice.6 When such gaps are identified by audit, the response has been to improve care by committee room decisions and stronger management. Repeat audit months later often shows little or no change in the quality of care.

The delivery of high quality care depends not just on the clinical acumen of the individual but also on the team surrounding that clinician and on the capability of the organisation in which care is delivered.7 More recently, improvement science has provided a mechanism of change that has delivered significant results by focusing on individual, team and organisational performance. For example, in 103 intensive care units in Michigan State USA the introduction of a programme incorporating evidence-based technical interventions (changes in clinical practice), non-technical interventions (linked to leadership, teamwork and culture change), and a centralised data collection and feedback system resulted in a 66% reduction in catheter-related bloodstream infections.8 These reductions were sustained and resulted in a reduction in mortality in participating ICUs when compared to controls.9 This quality improvement project over 18 months saved around 1,500 patient lives.

Matching Michigan has been introduced to ICUs in 97% of acute trusts in England as part of the Patient Safety First Campaign.10 Similar to the Safer Patients Initiative network11 and the Scottish Patient Safety Programme12 the driver of the Patient Safety First Campaign was to make patient safety a top priority and to create a mind-set of ‘no avoidable death and no avoidable harm’. There were five clinical interventions, all of which are relevant to anaesthesia, namely: leadership for safety, reducing harm in peri-operative care, reducing harm from high-risk medications, reducing harm from deterioration and reducing harm in critical care.

As anaesthetists we are at the centre of this agenda in our clinical and leadership roles in theatres, intensive care and across the hospital.
We have seen the introduction of a safety culture, surgical checklists and bundles of care to reduce ventilator associated pneumonias and catheter-related blood-stream infections. By following these and similar interventions the Scottish Patient Safety Programme has delivered a 124% reduction in hospital standardised mortality with 8,497 fewer than expected deaths.12 The methodology of these programmes is based on the Science of Improvement.

**What is improvement science?**

For most of us working in healthcare, improvement science is a new concept and one that has not been part of traditional training. Whilst the improvement methods are relatively new to the healthcare sector, they are long established in industry, agriculture and aviation.

The science of improvement was developed during World War II by W Edwards Deming (1900–1993) an American statistician and business consultant. He was credited with improving production in the US during the war, and in the 1950s used the same principles to kick-start Japanese manufacturing.13 He taught Japanese management how to improve service, quality, product testing, and sales with a variety of methods including the application of statistical control methods. Deming is regarded as having had more impact upon Japanese industry than any other individual of non-Japanese heritage. Later in the mid 1980s he is credited for starting Japanese manufacturing.13 He taught Japanese management how to improve service, quality, product testing, and sales with a variety of methods including the application of statistical control methods. Deming is regarded as having had more impact upon Japanese industry than any other individual of non-Japanese heritage.

The role of improvement science in anaesthesia?

The RCoA is in the process of incorporating Improvement Science into the new curriculum on a voluntary basis in the first instance. In addition, the most recent edition of the Royal College of Anaesthetists publication ‘Raising the Standard: a compendium of audit recipes (3rd Edition) 2012’ includes a section on quality improvement in anaesthesia.14 This covers in detail improvement science methodology and how this integrates with the more familiar area of clinical audit. The scope of this article can only offer an overview, so the reader is encouraged to access the compendium.

Caring for a patient is not the same as building a car. The manufacturing processes of building and assembling a car are relatively simple when compared to the management of a heterogeneous patient population with variable manifestations of disease. However, the improvement systems developed by Deming can be effectively applied to the clinical setting. The methods used are not only based on statistical science, but have also been tested and shown to work successfully to improve many different complex processes.

In addition to statistical process control methods, Deming used a technique which he called ‘profound knowledge’ to examine a system to see where it could be improved. This process involved four parts:

1. Appreciation of a system.
2. Knowledge of variation: a key to understanding the use of run charts and control charts.
3. Theory of knowledge – i.e. the concepts explaining knowledge and the limits of what can be known.
4. Knowledge of psychology.

A system cannot be improved without understanding each part. For instance, safety in theatre cannot be improved by just introducing a checklist:15 the cultural factors within the organisation have to be addressed.16 There needs to be an understanding of the way individuals behave within the team, the culture of that theatre and how the team interacts. In general, as anaesthetists, we concentrate on changing technical aspects of care, such as a new drug or a new piece of equipment, rather than organisational aspects. Changing how the operating theatre environment actually functions when caring for patients may provide a much greater opportunity for improvement than changing technical aspects.

‘Every system is perfectly designed to get the results it gets’

(P Batalden, Dartmouth Institute and the Institute for Healthcare Improvement)

As discussed, delivering healthcare is complex and made up of systems that are poorly understood and processes that have levels of reliability that would not be accepted outside healthcare.17 When measuring processes as part of improvement projects it is not uncommon to find reliability levels of 20–60% at the start of the project.18 For example, to improve perioperative outcomes in theatre we need to have a specific aim and understand the variables that impact on the delivery of that aim. There may be cultural factors such as the function of the team or specific interventions such as giving antibiotics on time. Without a specific aim or outcome that can be measured it is difficult to know when the system has been improved. To change any system there needs to be will, ideas and execution.

- You must have the will to make the system better – this may be because you have identified poor performance or outcome through audit or patient experience.
- You must have ideas about how you could change things for the better.
- You must have the skills to make it happen – execution.
One such example was part of a nationwide safety programme aimed to improve perioperative outcomes. How is this aim translated into achievable projects that the teams can improve? The first step was to understand the systems that the team could change using the model for improvement. A Driver diagram is a tool to understand your system and thus help a team identify the structures and processes driving an outcome, as well as forming the foundation for building a set of measures and a change package. In Figure 1 the primary drivers are preventing surgical site infections, creating a team culture and reducing adverse cardiac events. The primary drivers are then linked to secondary drivers that are specific processes or interventions that can be worked on by the team and improved (Figure 1). The secondary drivers can be combined as a ‘bundle’ of care.

The secondary drivers that make up the ‘bundle’ are preferably evidence-based interventions that are accepted by the team and are measurable. The team uses the model for improvement to develop processes that are 95% reliable. As the reliability of all of the secondary drivers reaches 95% then the team should see a parallel improvement in the outcome measures. Driver diagrams can be developed for any improvement project by the multidisciplinary team.

**The model for improvement**

This is the foundation tool used in improvement science developed by the Associates in Process Improvement and derived from the work of Shewhart and Deming. The model for improvement is familiar to many anaesthetists who have been part of one of the UK safety programmes such as the Safer Patients Initiative network and the Scottish Patient Safety Programme.

There are two essential parts to Deming’s model and the main method driving improvement is performing numerous small tests of change using...
the simple plan-do-study-act (PDSA) cycle (Figure 2). Change is made and delivered at the ‘coalface’ and not by committees in meeting rooms.

The first part asks three questions:

■ What are we trying to accomplish?
■ How will we know that a change is an improvement?
■ What changes can we make that will result in an improvement?

The first question, ‘what are we trying to accomplish?’, gives us our aim.

The second question is ‘how will we know that a change is an improvement?’. For this we will need to measure the outcome and processes that are being improved. Continuous measurement of compliance will provide feedback to the teams. The outcome measure should improve as the process measures become more reliable. Deming termed this ‘statistical process control’.

The second part is testing the changes using the plan-do-study-act (PDSA) cycle. This is simple and effective and is used to drive rapid cycle change. Small changes can be tested in one area and either rejected or accepted. While this may appear to be an apparently new concept, it differs very little from the concept of differential diagnosis and treatment plan practised in the art of medicine and anaesthesia. When accepted, the change is embedded into practice and spread to other areas.

In summary, as anaesthetists we have and will continue to be involved in delivering and leading improvement projects using the described methodology. The science of improvement does not threaten evidence-based medicine. To the contrary, it complements it making it easier for the practising anaesthetist to make changes that will result in safer, more effective, efficient, equitable, timely and person-centred perioperative care. 20

References

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10 Patient Safety First Interventions (www.patientssafetyfirstnhsuk) (last accessed 17 April 2013).
11 Scottish Patient Safety Programme (wwwscottishpatientsafetyprogramme.scot.nhs.uk/programme/resources) (last accessed 17 April 2013).
12 Hospital Standardised Mortality Ratios, *ISD Scotland* (wwwwiscotland.org/Health-Topes/Quality-Indicators/HSMR) (last accessed 17 April 2013).
17 Snowball A. Turning the NHS into a lean, mean, healthcare machine. *HSJ* 2012;122(6308):18–21.
From blog to book: making the leap

The journey in planning and writing a book is a long road requiring patience, dedication and, most of all, attention to detail. Do you have the beginnings of an idea about a new medical textbook? How do you take this idea and make it a reality? This article outlines the steps needed from having that idea, to developing and then guiding it through to publication.

Getting noticed
A wide range of publishers produce medical books, each with particular strengths and areas of focus. The major players include Oxford University Press, Cambridge University Press, Elsevier, Wiley-Blackwell, and Springer. Each of these publishers focuses on different specialties and, within each publisher, different commissioning editors concentrate on specific areas. There are two methods of initiating a potential project with a publisher. The first is to make individual contact with the relevant commissioning editor at a publishing house. All publishers have lists of commissioning editors on their websites and increasingly through social media sites like LinkedIn1 or Twitter.2 It is essential to identify the most appropriate team for your project, as a publisher not actively publishing in your field will reject your proposal out of hand. Once the correct person is identified, you now have a chance to pitch to them; this is best done as a ‘one-minute elevator pitch’ email. The editor should be excited by the idea; they are busy people and an idea is given more attention if presented in a succinct, approachable manner.

Right place right time
More infrequently, the second method is for a publishing house to contact an individual on the strength of work already published online or in paper. My interest in medical writing was ignited when a guide that I had produced on passing the Primary FRCA was published on AnaesthesiaUK.3 I decided to write an online diary, or ‘blog’, charting my preparation for the Final FRCA examination.4 Buoyed by a prominent link on AnaesthesiaUK, it gained some exposure nationally but really took off bizarrely after my initial attempt at the exam was unsuccessful; nothing like a sympathy vote to spur one’s efforts on. Clouds and silver linings spring to mind because, in addition to passing the exam second time round, the blog had caught the eye of a commissioning editor at Oxford University Press. Contact was made and the idea of a new textbook was born.

Team-talk
It is important to decide early in the project what format your writing team will take. You can opt to be sole or co-author with colleagues and take on all writing and proofreading duties. If it is your project, choose your co-authors carefully; reliability for deadlines is a key attribute. Advantages include greater control over the whole project and faster turnover at the proofreading stage; however, you will be responsible for all writing, which is a labour-intensive process. The alternative option is to be editor/co-editor and designate chapters or sections of your project to contributors. Advantages include less writing for yourself and the ability to utilise sub-specialty expertise (sometimes at national and international levels depending on your contacts); disadvantages include reliance on numerous individuals to perform and deliver against deadlines with potential delay in project progress.

Tactics and preparation
If the idea is considered to have potential, the commissioning editor will send you a proposal template document which will need to be drafted, sent for review, and put through a publisher’s approval process. An ill-thought out or hurried proposal will usually be torn apart at peer review and stop the project in its tracks. Proposal templates vary between publishers but broadly they cover the following areas.
Preface
The ‘one-minute sales pitch’ for the book; it needs to grab the attention of the reviewer. It should explain what the book will do, why it is needed, and why you are the person to write or edit it.

Market
This should explain precisely whom the book is targeted at, i.e. for a textbook on paediatric anaesthesia, it should explain it is aimed at paediatric anaesthetists and at what stage of their career. Don’t fall into the trap of putting as wide a market as possible down. Equally, the ubiquitous statement of ‘interested members of the public’ should be avoided, unless you have an extremely strong reason as to why non-medical professionals would be interested in the book.
Little worries a commissioning editor more than seeing ‘everyone’ listed as a potential market.

Contents lists
Often described as the ‘meat’ of the proposal, these should be as accurate and detailed as possible. A word count is needed for each chapter and your editor will hold you to this throughout the project. This is also the section that reviewers will scrutinise most closely and it should stand up to repeated viewings by your peers. The number of illustrations should also be considered here and the balance of line artwork and photographs. You should also state whether colour images are needed.

Competition
Unless your idea is truly unique, there will be some competitor titles, and these need to be listed. Under each competing title, a short but specific paragraph should explain why your proposed title would be superior to these titles; simply stating your book will be better is a weak argument.

CV
An up-to-date CV is needed for all authors; it may give an indication of why you are suitable to write this book. Having an experienced author on your team (especially if they have authoring history with the proposed publishers) lends strength to your proposal due to the presence of a proven publishing track record.

Sample pages
Not all publishers require sample pages, but if you can provide some so much the better. This allows the editor and reviewers to see if you can actually write and provides the best way of showing how the book will be presented.

Entering the competition
Once you have a final proposal, you need to discuss items like design, colour, and increasingly the electronic aspects of the book with your editor. They can run costs for the book to ensure economic viability; some further tweaks may be needed, e.g. shortening the text, to make it financially possible. The final proposal is then sent out to between four and ten peer reviewers. Depending on the seniority level of the reviewers and a myriad of other factors, the review process can take between two and six weeks. The editor will then send you the anonymised reviewers’ comments, which you will need to respond to.
This is perhaps the most crucial point of the process, as negative reviews may stop a project in its tracks, whereas positive reviews will invigorate a project and add momentum to it.

If the reviews are positive enough, the editor will then present the project to the publishing committee consisting of editors, the editorial director, marketing director, and marketing and sales teams. The project is discussed extensively and a decision is made whether to go ahead with it or not. At this point, within university presses, the proposal is sent to a board of delegates who are professors at the university and will provide the final approval. If successful, a contract is offered to all authors and then negotiated and signed. You will then be introduced to your project manager, who will become your first point of contact on the day-to-day management of the writing process.

Pushed to the limits
As with all first-time authors, I completely underestimated the time it would take to write our book. From submitting the proposal review to holding a copy in my hands took nearly 30 months. Even a short book will take a year to write and, if contributors are used, an 18-month schedule should be the shortest considered. The effort and energy required to produce high-quality work under time-pressure in addition to clinical and non-clinical work duties, and of course, most importantly, family commitments should not be taken lightly; I was threatened with divorce at least twice a month!

Communication with both your writing team and the publishers is the key to the writing process. Although not always possible, stick to agreed deadlines in the contract for submission of sections of the project, e.g. it was stipulated that 25% of the manuscript was to be submitted every three months in draft form in our project. This helps foster a good relationship with the publishing house and you will develop a reputation for being honest and reliable, possibly leading to further work in the future.
Don’t worry about telling your editor that the schedule will be longer than this; they would prefer an honest assessment of the time needed rather than an overoptimistic deadline that will then be missed.

As you come close to the completion of the book, and light appears at the end of the tunnel, you will reach the point of submitting it to the publisher. It is tempting to spend time formatting your work and fiddling with illustrations; however, unless you are writing into a template, publishers just want a Word document, which can then be flowed into the appropriate design for the book.
Importance of the approach
Once the manuscript is with the publisher, your project manager will commence preparation for the production process. Be prepared for lots of questions at this point and potential further work, e.g. clarification of copyright for any images used. Once the project manager is happy with the manuscript, they will hand it to a production editor, who will handle the production process. The production editor will outline this process in detail to you, but broadly it covers copyediting, typesetting, proofing and then printing. Due to the labour-intensive nature of all of these, this process typically takes between six to 12 months, depending on where the book is printed and how many sets of proofs are run through.

The final jump
This is also an opportunity to think about the marketing of the book. You will be sent a marketing information form, and it is important to include as much detail as possible on this form. This will be the key information with which the book is marketed.

At the end of the production process, there will come the big moment when your book publishes and you will receive an advance copy shortly ahead of publication. At this point, the marketing will have been in action for some time and you will see your book in medical bookshops and online. In the modern world of social media, blogging and Google™, this is also the opportunity to make a fuss about your book, to tell your friends and colleagues about it, and try and build a buzz around it. It is no coincidence that the bestselling books also have the most active authors.

Rewards
A quick word about money: will you get rich from medical writing? The short answer is no; a standard newcomer’s contract pays royalties of less than 10% of net receipts shared between all authors. Still, a nice cheque in the post bi-annually is the cherry on the cake of a marvellous achievement.

Finally, although this all seems like a long process, it is very much worth it. Little beats the feeling of seeing something you have crafted from bare bones and the mere inkling of an idea, sitting on the shelves of a bookshop or in your department with your name emblazoned on the front and colleagues turning to it for advice. It is a long journey but, like most long journeys, the destination is all the more rewarding for it.

References
3  http://passingthefinal.blogspot.co.uk.
On a mission to demystify the role of the anaesthetist, I undertook a three-week student selected component in the specialty at The University Hospital of South Manchester. Over the short time period, I aimed to understand the pros and cons of the job, and work out if the preconceptions of the ‘gas man’ are true, or just a load of hot air.

Peri-operative communicators
Let’s start with the well-known quip over anaesthetists’ ineptitude at communicating with their patients. After having been part of the team for a number of weeks now, how this came to be is a complete mystery to me – for although it is true that the patient is ‘asleep’ the majority of the time under their immediate care, I now appreciate that a lack of aptitude in this area would most certainly prevent an anaesthetist fulfilling their emerging peri-operative role. Without fantastic communication skills, it would be difficult to perform pre and postoperative assessments and share information with surgeons and theatre staff to deliver a medically stable patient throughout the whole process, whilst offering them and their families reassurance over their safety and long-term pain management. Besides, if this reputation fits anaesthetists, surely surgeons must also suffer the same prejudice, with their patients being in the same comatose state – and, for that matter, medical registrars should also come under scrutiny for being only interested in how far people can walk, what colour their sputum is and how their toilet habits have been lately. Indeed, absolutely every single anaesthetist encountered on this assignment has been none other than the most amiable, gregarious of characters, and therefore I hereby state that this myth is debunked.

Numberphobia
So communication skills are of utmost importance and, where they are not innate, hopefully the intensive communication skills training medical students now receive will help satisfy this criterion. But how does a numberphobe such as myself fare in the role? For, having sung their communicative praises, anaesthetists are also amongst my most feared species of the medical kingdom; those who not only understand, but seem to revel in the glory of graphs and equations, the cornerstones of those most formidable of subjects, maths and physics. Seemingly reasonable when explained first hand, upon opening a book on the subject, I become utterly flummoxed and it is to this end that I admire the more geeky disposition of some of those drawn to the specialty. In an attempt to fit in, however, I found that intimidating mathematic functions learnt through the practical applications of anaesthetics can really ease a mathematically naïve student into understanding that the numbers just serve to act as a precise and quantitative way of describing relationships between factors; just not in the wordy way I normally appreciate. Again, the mundane teachings of physiology and pharmacology may here seem to be a black mark against being drawn to a career that focuses so heavily on them, but on the contrary, anaesthetics brings the subjects to life in a hands-on, practical way, that delivers immediate results.

Back to basics
Indeed, anaesthesia is the only specialty I have so far observed that produces such quick reactions to the effects of intervention. This doesn’t just reflect the immediate effects of the induction of anaesthesia, but also the prompt recognition and treatment of subtle changes in vital signs that can otherwise rapidly lead to a dramatically unstable situation. Here, my time in anaesthetics really highlighted the importance of knowing the basics of ‘airway, breathing, circulation’ (not the ‘airway, book, coffee’ situations that students seem to bring to mind), which remain at the core of anaesthetics. A good grounding in these
fundamental principals provides a nice cushion to fall back onto where so much of medicine now focuses on overly complex, elaborate treatments that can often bemuse the innocent student output of a somewhat dubiously revered PBL (Problem Based Learning) education provided by some of our universities. At least the practical, clinical teaching in the course here is a strength.

The retention of their broad, fundamental knowledge base also enables anaesthetists to work in most types of surgery, keeping the job an interesting and varied one, with the potential to learn first hand the gossip of a great number of members of the different surgical teams. Seriously though, what really appeals here is the propensity for anaesthetists to translate their hugely varied experiences into management positions within the hospital, which adds a whole new dimension to the job that I had not previously considered.

High stress, high rewards
The instant management of potentially lethal conditions and the adrenaline rush that acute medical care provides understandably seem to draw many to the job, but, with the stakes so high, it proves an extremely stressful profession to be in. This lends itself to a certain personality then, and the anaesthetists demonstrated their many eclectic methods of dealing with such mental pressure. Where relaxation methods fail though, statistics demonstrating the high incidence of mental decline, substance abuse and suicide risk can be off-putting to a student. Yet with high stress comes high rewards, and surely no one would turn down the earning potential of a highly respected job in anaesthetics, with the flexibility, security and varied opportunities it offers. However, I now also acknowledge that with the prospect of such an exciting hands-on career as a consultant comes the sacrifice of personal time with long hours and on-call shifts creating a dubious timetable. A small stomach also appears beneficial, as breaks are few and far between. This contrasts not only with my own nutritional needs, but also with the sudoku whiz lifestyle that many think the anaesthetist adopts.

The trust that patients place in the hands of their anaesthetist, however, relying on them not only for their most innate of bodily functions whilst under the knife, but also holding them in such high esteem as their guides throughout the peri-operative process, can somewhat overshadow these potential drawbacks. Indeed, even as a student I felt a great sense of warmth and reward from the patients’ confidence in my skills, and their belief in the reassurances offered in the anaesthetics room before being ‘put under’.

Surgeons vs anaesthetists
When in theatre, patients and students (and TV producers) alike seem to hold a conventional belief that anaesthetists are somewhat subservient to their needy surgeon counterparts. Yet now I begin to see the underlying understanding that the anaesthetists are just lying dormant until something goes awry, as it is in those split second moments that the anaesthetist, unequivocally in charge, really has their time to shine – when their immense capacity to make sensible, logical decisions in the face of immense pressure and panic saves lives.

You would think, then, that surgeons would treat their anaesthetists with the utmost respect. This is almost always the case, yet there is always the one who arrives late and invariably complains about the length of time the anaesthetic is taking to be administered. Where the surgery lends itself, it is here that the sterile screen (otherwise known as the Blood-Brain Barrier) is a godsend. It is true too that every good surgeon deserves a great anaesthetist, and every bad surgeon needs one. In general, however, the banter between the two conflicting specialties made the job all the more enjoyable. Without the immense advances in anaesthesia and intensive care, remember, none of the high profile developments in surgery could ever have come to fruition. Indeed, before the use of general anaesthetics, surgery was performed only in the most extreme of circumstances. Although this did come with some benefits – where a below knee amputation used to be complete in around 30 seconds, this timeframe didn’t seem to differ altogether much with the subsequent lifespans of the patients.

A vague science
These anaesthetic advances are down to the research backbone that the specialty seems to pride itself on, somewhat surprising as some anaesthetists not only admit themselves that their job is a ‘vague science’ but also the fact that still no one knows precisely the exact molecular mechanisms of how all the drugs of their trade work. In fact where plausible solutions have been postulated, further research invariably overturns their conclusions (think the out-dated Meyer-Overton lipid theory!) and consciousness therefore remains one of the great mysteries of life. Considering this is the foundation of all anaesthesia, it is perhaps unnerving (f) to induce it when so little is known. That is not to say that research in the area is altogether failing to answer the mystery of life’s rich tapestry – on the contrary, with works producing results with such gravity as ‘redheads need 20% more anaesthesia’, it is hard not to be drawn to the research ethic behind the job. Besides, with very few answers being known, there is a lot of opportunity for new discovery.

A business opportunity?
Here, I believe my questioning and budding innovation of mind may flourish. Indeed, I believe I have already stumbled upon the jackpot – for, perhaps influenced too much by a patient under analgesia, we
decided to go into business together. We theorised over a ‘beauty salon’ takeover of the ER – Coco Chanel scented sevoflurane, iodine fake tan and perhaps a pedicure during the operation. After all, already introduced are massaging leg stockings. The scrubs do suit the role, though I’m not sure people would trust a beautician with such a bad taste in ill-fitting hats. On a vaguely more sensible note, an audit into the effectiveness of ethyl chloride for testing the potency of nerve blocks may be called for – never before has it been so humorous to watch the frustrations of a doctor, or the building stress of the surgeons; do you feel a cold sensation here? Is it the same here?! a phrase that shall be dearly missed after my time in the anaesthetics room.

Want to apply?
So, to conclude, most of what I believed about anaesthetics, based on the highly general judgements of the rest of the medical population, has been completely and thoroughly overturned in just a matter of weeks. Although anaesthetists shall ever be respected as some of the brightest minds the medical profession has to offer, it turns out they are also some of the most lovely people anyone could ever hope to come across, with a modesty that completely betrays the amazing skills they possess to take control and bring back life from the edge. Defying the lyrics of the ‘Amateur Transplants’ to the wondrous tune of Bonnie Tyler then, I can categorically state that anaesthetics is not just listening to blips of the heart. Only those with an innovative, research orientated mind who are intellectually adept and self-motivated in a way that enables them to cope under extreme pressure whilst having an empathetic and gregarious nature need therefore apply! The question is, do I? They are skills I am definitely going to have to work on, as after these three weeks, anaesthetics is most definitely a profession that I would consider entering!

Acknowledgements
With many thanks to Dr Elias Delis, who made my all too brief navigation through anaesthetics so enlightening.

References
The GASagain course – a national network

In January 2010, the Royal College of Anaesthetists published an article in the College Bulletin together with a guidance document entitled: ‘Recommendations for supporting a successful return to work after a period of absence’. This article helped in increasing awareness for the need of a ‘structured’ return to work package. The guidance was further updated in May 2012 ‘Returning to work after a period of absence’,1 to reflect the findings from the Academy of Medical Royal Colleges (AoMRC) ‘Returning to Practice guidance’. These documents provide a framework for assessing the needs of the returning individual, and for the promotion of a tailored programme.2

An anaesthetist may be away from their normal work environment for many reasons and, as these periods of absence can extend from months to years, a ‘return to work’ package may need to incorporate a major retraining component. The guidance highlights the role of medium or high fidelity simulation ‘to enable exposure to uncommon events and team training in a non-threatening environment’.3 It stresses the importance of ensuring safe, consistent, high quality care for patients in conjunction with supporting our colleagues at a vulnerable time.

The GASagain course!

One of the tools mentioned in the ‘structured’ return to work package is a ‘return to work’ simulation day. A multicentre, national network of the GASagain4 (Giving Anaesthesia Safely again) course has been established. The course is currently held in three centres – London, Bradford and Bournemouth. The day offers a valuable opportunity for the anaesthetist to gain confidence, update, explore team skills, manage crises and make decisions, with a group of individuals who have similar concerns, in a safe environment.

What the day involves?

The day is a mix of simulation scenarios and interactive workshops and updates, covering a wide range of topics. The course structure ensures that there is a workshop or update prior to the simulation scenario. The ‘hands on-experience’ in the interactive workshops gives the participants a chance to practise without ‘real’ patients, to go through algorithms or guidelines and to ask questions they might not want to ask in the workplace. The facilitatory debrief style of simulation suits the participant who has past experience, has previously attended lectures, knows where to access knowledge and has views to share with the group. A pre-course e-booklet offers concise information about important algorithms and recent guidelines/recommendations.

The course faculty are experienced anaesthetists, who have a good understanding of return to work issues mainly as they have experienced it themselves. The design of the course necessitates a high faculty to participant ratio to run the small workshops and the simulations, and to provide one-to-one support.

The feedback so far...

The first course was held on 7 April 2011 at UCLH Education Centre, London, with Dr Carolyn Evans, the RCoA Bernard Johnson Advisor in attendance as an observer. In total, 38 participants have taken part in the five GASagain courses held to date, of whom 36 submitted the feedback form. The participants were a mix of consultants (three), specialty doctors (two) and trainees (31). All the participants agreed or strongly agreed that the course programme was interesting, met their learning needs and matched their expectations.

All the participants felt that the day would increase patient safety and quality of care. All participants felt that it had increased their confidence, 86% of the participants strongly agreed/agreed that the day had helped in increasing their knowledge, 89% of the participants strongly agreed/agreed that the course had helped in reducing their worries about returning to work, and all the participants were satisfied with the training they had received on the day.

The GASagain day meets a growing demand for simulation training as part of a return to work package. The shared experiences of the multicentre faculty have led to improvements
and standardisation of the course. It has also promoted a national vision and collaboration for return to work practice. This course also has the capacity to be used by any anaesthetist as a broad refresher, covers a number of revalidation codes and has been awarded 5 CPD points.

The faculty includes (and travels to other centres):

London – Annie Hunningher, Anna Fowler, Caroline Cormack, Caroline Pritchard, Trudi Young, Seema Randive, Helen Ahmad, Priya Suares, Hasanthi Gooneratne, Niven Akotia, Jo Makepeace, Sarah Chievelley-Williams, Clinton John, Jonaline James, Lawrence Ignatio, Isabelle Hamilton-Bower (resus officer), Kate Baille (resus officer)

Bradford – Jill Horn, Dawn Fabbroni, Caz Farrow, Mark Fairbrass, Maria Garside, Louise Savic, Louise Jobling, Andrew Sykes, Debbie Horner

Bournemouth – Isabel Smith, Fran Haigh, Lisa Morgan

The future dates for the course are:

**Bournemouth**
Tuesday, 2 July 2013

**Bradford**
Wednesday, 17 July 2013

**London**
Wednesday, 18 September 2013

For further information, please visit the website: www.gasagain.com or send an email to gasagain@gasagain.com.

**References**

4. The GASagain website (www.gasagain.com).
College Tutors Meeting Poster Competition

Education and training are core activities of the Royal College of Anaesthetists, and many aspects of training and education are discussed every year at the annual College Tutors’ meeting, held this year in Manchester last month. For this first time, we invited trainees to submit abstracts describing work relating to educational activity that they have performed for presentation at the meeting, with prizes offered for the best presentations.

We received 61 submissions, of which 47 were accepted for presentation. Three submissions were presented orally at the meeting, and their abstracts are reproduced below. The variety of the work presented was impressive, and that is represented in these abstracts – Drs Conlon and Lomas present work on their online airway training resource, Drs Pidgeon, Samuels and Carey investigate the relationship between CT1 recruitment and educational progress, and Dr Skog and colleagues report their intervention aimed to improve competence of trainees joining an on-call rota for the first time. All the authors are commended for their work.

The North West Airway Management Database (NWAD) – a reporting system to improve patient safety and airway management training
Dr C E Conlon and Dr J P Lomas, North West Deanery
www.eanaesthesia.com/nwad

Demonstration of exemplary airway management is the most fundamental skill of the anaesthetist. Of all complications related to anaesthesia, airway complications most commonly lead to death or brain damage.1

Advancement of airway management skills requires exposure to challenging airways but direct clinical experience is inconsistent and inadequate due to a paucity of clinical cases.2–3 NWAD is a vehicle to share airway management experiences. This compensates for the lack of direct clinical experience and improves airway management training, clinical performance and patient safety.

Participants register at www.eanaesthesia.com/nwad, allowing them to submit and review case reports. Submitted cases are examined prior to publication by regional airway management experts. Reported cases are more reliably and easily recalled.4

Analysis of adverse events identifies inexperience, poor judgement, and education and training to be frequent contributory causes in airway misadventure. NWAD reduces the risk of similar events by enhancing understanding of the factors that influence patient outcome. It fosters a culture of openness, providing the opportunity to discuss cases openly without fear and for the profession to learn lessons from others by offering up their own experiences.

References
Recruitment to anaesthesia has been subject to some change over recent years, with the move to testing non-technical skills being seen as a positive development to aid candidate selection.\(^1\)

We sought to evaluate whether the scores obtained at CT1 interview could predict the likelihood of an ARCP outcome 1 at CT2 thus indicating successful completion of basic level training within the two-year Core Training programme.

37 candidates were appointed to Core Training rotations in 2010; one had left the programme prior to CT2 ARCP and one was on maternity leave. Anonymised data were analysed from the remaining 35 trainees who had attended ARCP. Scores at the three interview stations used in the 2010 recruitment campaign were recorded and the data were separated into those who achieved outcome 1 at ARCP in 2012 and those who did not. The score at each interview station for both groups was compared using the Wilcoxon signed rank test as data were non-parametric.

23 candidates achieved outcome 1 at CT2 ARCP; 12 did not. There was no statistical difference in the scores in any of the three interview stations nor in the overall interview scores between the two groups. No part of the interview scoring process was positively associated with successful CT2 ARCP outcome in the cohort studied.

Although we only have a small dataset, in this study no aspect of the interview process was predictive for a successful outcome at CT2. There is an inherent question as to whether the CT1 interview process should be designed to select those who are most likely to complete Basic Level Training within two years or should select trainees with the skills to become successful consultants. Since anaesthetic training has become uncoupled, the latter criteria would arguably be better addressed by the ST3 interview process.

In our sample, all candidates were unsuccessful at CT2 ARCP solely due to failure to obtain the Primary FRCA. This raises the question whether there should be an element of a standardised theoretical knowledge tested at interview or the introduction of a ranked ‘exit’ exam at the end of F2, similar to the USA model. It may also be useful if medical degrees were standardised and graded in some way to give a better indication of the academic calibre of candidates.

### Reference

The RIACT course

Dr A Skog, ST6, Oxford Deanery
Dr P Shanmuga, ST5, Oxford Deanery
Dr S-A Shiels, ST3, Oxford Deanery
Dr A Ankers, Consultant Anaesthetist and College Tutor, Stoke Mandeville Hospital, Buckinghamshire
Dr S Snyders, Consultant Anaesthetist, Stoke Mandeville Hospital, Buckinghamshire
Mrs J Wright, Resuscitation Lead, Buckinghamshire Healthcare NHS Trust

As trainees have reduced their overall hours, making every interaction a training opportunity becomes even more important. This is especially important at the start of anaesthetic training as the Initial Assessment of Competence (IAC) requires the attainment of significant competencies within a limited time. Indeed, in a recent national survey 21% of anaesthetic trainees had not attained their IAC prior to going on-call. The IAC is a requirement not only for anaesthetic trainees but also ACCS and, in the future, intensive care medicine (ICM) trainees. Providing a teaching and training programme within an anaesthetic department for a small number of trainees with specific educational needs can be logistically challenging.

The Readiness for the Initial Assessment of Competence Training (RIACT) course aims to address this training need by providing IAC focused teaching for new starting anaesthetic, ACCS and ICM trainees. The course takes place biannually in the Oxford Deanery with six teaching days spread over the first three months of training. The primary aim is to provide trainees with the knowledge, training and educational material to maximise every learning opportunity within their base hospitals. Medium, high fidelity and part-task simulation together with lectures, small group teaching, and workshops teach the knowledge and skills specified in the IAC. The RIACT website provides course e-learning material and acts as a portal to established educational resources, e.g. the e-Learning for Healthcare portal. During the final day of the course the trainees undergo a standardised assessment performance a simulated failed intubation drill with College tutors from each hospital trust forming an assessment panel.

‘Competence is much more than the accumulation of a string of competencies.’ This sentiment was reflected by RIACT course participants who highlighted specific concerns about safely joining the on-call rota. As a result of this feedback the RIACT course has developed into a course that not only helps to teach the competencies specified in the IAC, but also provides logistical and practical support to facilitate the transition from a novice training period to safely joining the on-call rota. Importantly, trainees felt that this course would ultimately reduce errors and improve patient safety. Post course feedback is shown below:

August and February start dates for training provide an opportunity for a deanery-wide IAC training course. The RIACT course (or similar) could be readily replicated, in whole or in part, in other deaneries. We would gladly share any educational material and the e-learning framework which can be accessed via the login pages of the website. Further course information can be found at: www.riact.org.uk or email: riactcourse@gmail.com.

References

To what extent do you agree with the following statements: The ‘RIACT’ course ...
Guidance on managing the poorly performing anaesthetist

Dr A-M Rollin, RCoA Professional Standards Advisor

Where performance is outside the accepted limits of practice, the anaesthetist in question potentially poses a risk to patient safety and the effective delivery of medical care by departments. If poor performance is suspected, the situation must be managed and this, in turn, is governed by a complex set of arrangements. With this in mind the College has recently issued new guidance on managing the poorly performing anaesthetist, aimed at clinical directors and others in managerial positions, and takes into account recent GMC policy and Department of Health initiatives.

The guidance is divided into six main sections:

- Definition of the poorly performing anaesthetist.
- Prevention of poor performance.
- Being alert to concerns.
- Principles in managing the poorly performing anaesthetist.
- Local (trust/health board) procedures.
- Procedures involving external agencies.

A list of sources for further advice, together with links to key supporting documents and resources, is also provided in the guidance document.

Managing performance concerns in an individual, who may be a close colleague or friend of many years, is always going to be difficult. Demands will be made on the Clinical Director to view the situation objectively and their actions should be benchmarked to the fundamental principles outlined in the guidance. Uppermost is the need to protect patients, while at the same time ensuring that the anaesthetist is treated justly. Most situations are retrievable and opportunities should be provided for performance improvement. Appropriate standards and milestones, against which improvement gains can be assessed, must be identified from the outset.

Being alert to concerns is largely dependent on good clinical governance structures being in place, although external sources (e.g. Healthcare Professional Alert Notices) may also set off alarm bells. The majority of concerns will be low risk and should be dealt with locally/informally before they escalate to something more serious, causing harm to patients. A forthright private conversation with trusted senior colleagues may be sufficient to resolve the situation in the first instance.

Where the anaesthetist has no insight into the performance problem, or the concern is serious and/or patients are being put at risk, formal procedures should be activated. Exclusion from work may need to be considered as well as seeking the advice or involvement of external agencies, such as the NCAS and RCoA Anaesthesia Review Team. In England, the idea of NHS Regional/Area Professional Support Units is being promoted, to provide trusts with access to an expert shared support resource in responding to concerns.

In some cases it may be inevitable that an anaesthetist is referred to GMC Fitness to Practise procedures. Criteria for referral include situations where local action by a trust would be impractical or has been tried but has failed to resolve the problem, or has resolved the immediate issue but the matter has wider implications. Immediate referral to the GMC may be necessary (without local action being taken first) where the problem is so serious that this is the only obvious course of action. Doctors whose fitness to practise is called into question are now considered by the Medical Practitioners Tribunal Service. The MPTS is part of, but operationally separate from, the GMC and has powers to impose sanctions against a doctor’s registration where necessary.

To download the guidance go to: www.rcoa.ac.uk.
Senior Fellows Club

23 May 2013

The spring meeting was held at the College and attended by 82 members. The chairman opened the meeting by welcoming members particularly the new ones. She thanked Dr Ann Ferguson for the compilation of exhibitions in London, and Rosemary Sayce and Karen Slater for the administrative arrangements of the meeting.

Professor Tony Wildsmith, the Honorary Archivist of the College, was invited to explain to members about the ‘Lives of Fellows’ project. The purpose is to record the ‘heritage’ of the specialty by recording Fellows’ professional and non-professional information bearing in mind two significant anniversaries in the near future: the 25th of being ‘royal’ in 2017 and the 75th of Anaesthesia being a separate specialty in 2023. He wanted to know members’ views and suggestions on the design of a recording form and where he could find missing documentation particularly of the ‘pioneers’ of the specialty and he would be grateful if members could contact him by email jaww@doctors.org.uk.

The chairman then asked Dr Peter Venn, a member of Council and Chair of the Standards Committee, who was deputising for the President, to give an update on College matters. He reported that:

- Professor David Greenway’s independent Review of the Shape of Medical Training is expected to be published in the summer.
- There has been discussion about whether the college should change its name to reflect and recognise the wider role of anaesthetists who are increasingly becoming perioperative physicians and spending a greater proportion of their time outside of the operating theatre.
- ACSA (Anaesthetic Clinical Services Accreditation) will enable the College to interact with anaesthetic departments more closely than it has been able to do so in the recent past. It will be a four year peer review based on 68 bench marks on the quality of healthcare and training, and will be in keeping with the spirit of the report of the Francis Inquiry. This will commence in June 2013.

The chairman introduced the guest speaker, Dr John Meadley MBE, who has worked in Africa, Asia and the Caribbean, first as an academic and then as a consultant in economic development. The title of his talk was ‘Development Aid – stimulant or anaesthetic?’ He began by stressing the difference between humanitarian aid (which is aid mainly given during emergencies, such as food aid and social protection) and development aid (which is aid given by governments and agencies to achieve the eight millennium goals). He used the example of giving food (humanitarian) versus giving the means of producing food (development). Dr Meadley’s talk was based on his experience and personal perspective of development aid.

Development aid is global and complex. There are two main sources of aid: grant aid from governments and non-governmental bodies such as charities and the Gates Foundation, and non-grant aid which lends money long term and on low interest rates such as the World Bank.

Projects cover key areas including health, education, food production, governance, family planning, technical assistance, research, conflict prevention and trade. In 2012 the OECD (Organisation for Economic Cooperation and Development) countries contributed £90 billion in aid, out of which the British aid budget (mainly delivered through the Department for International Development (DfID)) was £11.3bn. It is currently the sixth highest contributor on a per capita basis. This will rise to £14bn in 2014 when the UK reaches its target of 0.7% of Gross National Income.

In comparison the Gates Foundation donates around £2.3bn annually. Health services development gets the highest contribution. Africa gets about half of the contribution, Asia about a third and the remainder goes mainly to the South American countries. Dr Meadley showed some examples of aid in action and of his current work in Zambia and India.

Despite some scepticism in the media, Dr Meadley maintained that development aid is essential not just because of a basic concern for the vulnerable and underprivileged but also for developing new markets, to prevent conflict, to advance equality and to avert mass migration.

The chairman thanked Dr Meadley for a clear and thorough explanation of the subject and invited members with questions and comments to approach him during lunch.

In conclusion the chairman announced that members will be able to bring guests to the next meeting in Newcastle and that a small list of hotels and restaurants was on the back of the programme.

Date of next meeting

The next meeting of the Senior Fellows Club will be held at the Assembly Rooms, Newcastle on Thursday, 17 October, when the speaker will be Professor John Norman.
Introduction
Starting as a novice anaesthetist can be a daunting experience for trainees. Many have had little or no exposure to anaesthesia during their foundation or medical school years. A new working environment, new drugs and the requirement to rapidly acquire both a new set of skills and the knowledge base to support them, results in a very steep learning curve in the early stages of training.

During their first three to six months, trainees are expected to complete their Initial Assessment of Competence and the 8 Basis of Anaesthetic Practice training units. Although there are many resources available online and through the College Tutor network to support trainees during this key stage of their training, they can often be difficult to find. The Imperial School of Anaesthesia highlighted the value of creating a ‘one-stop shop’ for the essential information required by novices in the last edition of the Bulletin.

In late 2012, the RCoA Council approved the formation of a working group to create a starter pack for novice trainees. In addition to welcoming them to the specialty, it would include the key information and learning resources required during their first three to six months of training.

The Guide for Novice Trainees working group met in February 2013 to define/agree the contents and format of the resource. The group included representatives from Training, Education, e-Learning, the Trainee Committee and the Imperial School of Anaesthesia Novice Course. Given the relatively short time frame for delivery of the project and to minimise costs, all further activity was conducted electronically.

Format and distribution
It was agreed that the guide would be distributed to all novice trainees one month before starting their training programme, on a USB memory stick. The resources on the memory stick would be accessible using any browser and a ‘website’ style graphical user interface was designed to facilitate navigation. Trainees or trainers can copy the entire guide to run off their own hard disk.

Overview and structure of the guide
The contents of the guide are organised under eight main headings as detailed below:
- Home
- Introduction
- Novice Curriculum
- e-Learning Anaesthesia
- Getting Started
- Other Resources
- Tips and Tricks
- Help and Support

Positioning the mouse over a menu item gives the user access to the submenu structure and the contents of each section. The interface and navigation structure is simple to use, requiring little or no training (Figure 1). Pages and resources in the guide are accessed either directly from a menu item or from links within individual pages. Key documents and resources that a trainee may need to print or save to a smartphone open in a new window. Extensive cross-referencing allows the user to access resources from different sections in the guide. A small number of resources require internet access.

Home and introduction
The Home page contains a welcome message from the President and a brief history of the College. The Introduction section contains information about the contents of the guide and how it can be used, plus an overview of the training programme, including who’s who, assessments and key contacts.

Novice curriculum
This section contains an overview of the novice curriculum, the IAC and each Basis of Anaesthetic Practice training unit. In each training unit, the information presented to the trainee includes the main learning objectives, a link to the specific section of the curriculum, links to the relevant e-Learning sessions from...
Module 1 of e-LA and the AAGBI glossies/guidelines referenced in the curriculum. All are contained on the memory stick so the user does not have to have internet access to view the documents (Figure 2).

**e-Learning Anaesthesia**

This section contains an overview of e-LA and how to access the programme through the e-LfH Learning Management System. The 78 sessions from e-LA Module 1: Introduction to Clinical Anaesthesia have been loaded onto the memory stick (Figure 3). This module was specifically designed to cover the knowledge base required by novice anaesthetists. Making the sessions accessible offline enables trainees and trainers to use them as a framework to support in theatre teaching, without the need to log in. As demonstrated in the novice curriculum section, you will also find links back to the e-Learning sessions throughout the resource.

**Getting started**

The trainees on the working group felt strongly that there should be clearer guidance on what trainees are expected to do at, or by, various points in the first three to six months. We have therefore included a Timeline and Milestones section, as well as information and practical advice on pre-assessment, preparing your theatre, basic anaesthetic types, recovery and post op visits, on-call and anaesthetic emergencies. Where possible, we have included direct links to relevant resources in other parts of the guide.

**Other resources**

As an extension of the ‘one-stop shop’ concept, this section contains a collection of the key guidelines relevant to novice training from the AAGBI, Resuscitation Council and Difficult Airway Society, in addition to a useful ‘aide-mémoire’ of basic anaesthetic drugs; all of which can be printed or sent to a smartphone in PDF format. Guidance on how to keep a logbook,
as well as information regarding the various online tools available from the RCoA, is also included.

**Tips and tricks**
This contains guidance on professionalism, how to get the most out of your training and a trainee focused Frequently Asked Questions section.

**Help and support**
Recognising that some trainees can find the first few months difficult or unsettling, the working group have included this short section with general guidance on how to get help and support.

**How to use the Guide for Novice Trainees**
The guide will be available as a USB memory stick from July 2013 and will be distributed to all new trainees and College Tutors. There has been extensive consultation with key stakeholders during the development process, to ensure a balanced approach to the resources included on it. In addition to creating a 'one-stop shop' resource, the working group have also tried, wherever possible, to integrate the resources to facilitate learning and present the information in a co-ordinated way.

The Guide for Novice Trainees has been designed as a learning resource, not as a prescriptive course. There are no right or wrong ways to use it. The working group hope that both novice trainees and trainers will find it a useful resource that supports the key first few months on the training programme. The working group would welcome feedback from users regarding the contents and/or structure of the guide, for consideration for future editions. Please send comments regarding this to: Natalie Bell (nbell@rcoa.ac.uk).

**Acknowledgement**
With thanks to:

- Instructional Designer – Mr Nick Cleary.
- Training Programme Director – Dr Ralph Leighton.
- Board Member of Imperial School Novice Course – Dr Himala de Zoysa.
- Imperial School Academic Trainee Representative – Dr Kate Tatham.
- Imperial School Post-fellowship Trainee Representative – Dr Claire Boynton.
- RCoA Trainee Committee Representative – Dr Gethin Pugh (ST5).
- RCoA Trainee Representative – Dr Duncan Wagstaff (CT1).
- RCoA Training Manager – Miss Claudia Moran.
- RCoA PA to the Director of Education and Research – Miss Natalie Bell.
Small Grants and Awards

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

Applications are invited for the following funds:

**Ernest Leach Research Fund**
This fund was established in June 2011 to be utilised for the purposes of research.
**Value up to £2,500**

**Stanley Rowbotham Fund**
For education in anaesthesia.
**Value up to £2,500**

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

**To apply**
Please visit www.niaa.org.uk/article.php?article=89 to view the assessment criteria and download a copy of the application form. The deadline for applications is **Friday, 30 August 2013**.

**Payne Stafford Tan Award – An Award for Clinical Excellence**
This award was originally established through the generosity of an American friend of the College, Mr Norman Knight. The aim of the prize is to mark excellence in clinical practice, teaching or research in anaesthesia, critical care or pain management. The award is open to any Fellow or Member of the College, and comprises a grant (to a maximum of £1,000) to be used for educational purposes such as attendance at a major conference or the purchase of educational materials. The recipient will be expected to provide a short report outlining how the funds have been used.

**To apply**
Nominations are now invited for the 2013 award, and must be made by a Fellow or Member of the College. The nomination should be in the form of a letter outlining the particular merits of the individual nominated, and should be accompanied by a full curriculum vitae for that individual. Self nominations are also permitted. Nominations should be sent to the NIAA Administrator at the address below by **Friday, 30 August 2013**.

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

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

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

Applications for Macintosh Professorships are open to Fellows and Members of the Royal College of Anaesthetists and other clinicians and scientists involved in anaesthesia, critical care and pain management within the United Kingdom. Applications will be considered by the Board of the National Institute of Academic Anaesthesia and expert external advisers.

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

**To apply**
Please submit a synopsis of your proposed lecture, along with a CV and covering letter by email and post to the NIAA Administrator at the address below by **Friday, 30 August 2013**.

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

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

The criteria for this prize have now been extended and the prize will be awarded to the anaesthetic or intensive care trainee who is the principal author of the best paper relating to the management of acutely ill patients published, or accepted for publication, in a peer-reviewed journal.
To apply
If you are such a trainee and would like to apply for the prize and have published such an article since 1 August 2012, please submit your article by email and post to the address below, along with a copy of your CV and a covering letter by Friday, 30 August 2013. A prize of £500 is available this year.

Society for Education in Anaesthesia UK (SEA UK) Awards

The Greaves Award, Kumar Award and Myerson Award
These three grants are awarded by SEA UK and were established in 2011 to recognise the contributions of Dr David Greaves, Dr Keith Myerson and Prof Chandra Kumar in founding SEA UK. They are intended to support travel and research connected with projects that are educational in anaesthesia, critical care or pain. Each award is worth up to £500.

- Recipients of grants must present a report for publication in the SEA UK Newsletter.
- Non-members may apply but would be expected to become a member of SEA UK.

Full details and an application form can be found on the NIAA website at: www.niaa.org.uk/article.php?newsid=131 and the deadline for applications is Friday, 30 August 2013.

Applications for the above grants, awards and prizes should be sent to the NIAA Administrator, Miss Clare Bunnell, by post and email at: The Royal College of Anaesthetists, Churchill House, 35 Red Lion Square, London WC1R 4SG email: cbunnell@rcoa.ac.uk.

Examinerships 2014–2015

The College invites applications for vacancies to the Board of Examiners in the Fellowship of the Royal College of Anaesthetists, from the academic year 2014–2015. Examiners will be recruited to the Primary examination in the first instance. The number of Examiners required will reflect the number of retirements from the current Board of Examiners.

Applicants shall be assessed against the following person specification:

a Essential
1. Shall normally be a Fellow by Examination, but a Fellow ad eundem, or a Fellow by election of the Royal College of Anaesthetists will also be considered.
2. Shall be in good standing with the College.
3. Applicants must be able to demonstrate that they have the competence, confidence and credibility to assess the next generation of consultants.
4. Shall currently be active in clinical practice in the NHS or a comparable post.
5. On 1 September 2014 shall have the expectation of completing at least ten years as an examiner whilst filling a Specialty Doctor/SAS grade or Consultant appointment in the NHS, or comparable post.
6. Can demonstrate active involvement in the training and assessment of trainees.
7. Good written and verbal communication skills.
8. Ability to work as part of a team.
9. Documentary evidence of satisfactory completion of Equal Opportunities training in the last five years.
10. Able to commit to long-term and active involvement to examiner duties including the ability to devote a minimum of 12 days per academic year to the role. This includes both the delivery and development of the examinations.

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

Application forms and information for applicants can be downloaded from the examinations section of the College website (www.rcoa.ac.uk/node/313) or can be obtained from Miss Chloe Scrivener, Training and Examinations Directorate (020 7092 1525 or cscrivener@rcoa.ac.uk).

The closing date for receipt of completed application forms is Monday, 14 October 2013.
Ceremony of Diplomates 2013

At the Diplomates Ceremony on Friday, 3 May 2013, the following awards were presented:

**Fellowship by Election**
- Professor Tim Hales
- Dr Jeanne Moriarty

**Humphry Davy Award**
- Dr Jerry Cashman

**Dudley Buxton Prize**
- Dr Paul Murphy

**Nuffield Medal**
- Dr Mark Burtonwood
- Dr James Reid

**Macintosh Medal**
- Dr Ben Harris

**Magill Medal**
- Dr Kris Bauchmuller

This year the Ceremony was held at Central Hall Westminster, London

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**Humphry Davy Award**

**Dr Jerry Cashman**

Dr Jeremy Cashman has been a long-standing servant of the College over a number of years and it is wholly appropriate that his many achievements are recognised today by the award of the Humphry Davy Medal.

Following undergraduate education at St George’s Hospital Medical School, Jerry trained in anaesthesia predominantly at Guy’s Hospital before returning in 1989 to his alma mater as consultant with an interest in cardio-thoracic anaesthesia and acute pain management. Throughout his consultant career, Jerry has maintained tireless enthusiasm as a respected clinician, teacher, academic, examiner and medical manager. Awarded an MD in 2005 for a thesis on the use of non-steroidal anti-inflammatory drugs in post-operative pain management, he has authored over 80 publications including 40 peer-reviewed papers and ten books. A former editor of the *European Journal of Anaesthesiology*, he currently co-edits ‘Lee’s Synopsis of Anaesthesia’. This iconic textbook, now in its 13th edition, is still venerated worldwide as the ‘Bible’ of British anaesthetic practice.

An FRCA examiner for ten years, he developed, in an incredibly short time frame, the gamut of resuscitation scenarios for the new Primary examination. The College is indebted to him for taking on at short notice the directorship of the Final FRCA revision course in 2007 when he breathed new life into this well established learning resource from which many of you here today have obviously benefited. As a founding member of the examining board for the Fellowship of Faculty of Pain Medicine, he has brought his previous experience to bear as the lead question writer where his influence is proving pivotal in the successful introduction of this new examination.

The Humphry Davy Medal is given to an individual for sustained contribution to the work of the College, involving high levels of commitment and delivery over a number of years. Jerry’s work is rightly recognised by this award.

**Citation by Dr Liam Brennan**

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**Dudley Buxton Prize**

**Dr Paul Murphy**

It gives me great pleasure to present to you Dr Paul Murphy for the award of the Dudley Buxton Medal, in recognition of his outstanding contributions to the science and practice of anaesthesia and intensive care medicine, particularly in the field of organ donation and transplantation.

Dr Paul Murphy qualified in medicine in 1985 from the universities of Cambridge and Bristol, and after training in anaesthesia was appointed Consultant in Neuroanaesthesia and Critical Care in Leeds in 1995. He has served as College Tutor for Anaesthesia, Clinical Director for Anaesthesia, and Clinical Centre Director for Critical Care Services while also setting up the neurocritical care service.

In 2005 Dr Murphy was invited to join the UK Transplant Donation Advisory Group and become a member of the Department of Health’s Organ Donation Taskforce as one of two intensive care representatives. In 2008 he was appointed NHS Blood and Transplant (NHSBT) National Clinical Lead for Organ Donation. In this capacity he has delivered all the objectives set by the Taskforce and Programme Board, including establishing a clinical lead and specialist nurse for organ donation in each acute hospital in England, creating a national network and clinical community to improve donation rates and support for bereaved families. He has also successfully introduced donation after circulatory arrest, a particularly challenging circumstance for families and staff.

He has authored 29 publications in the last five years, adopting an evidence-based approach to evaluating organ donation services, and is now providing expert guidance to other countries on donation after circulatory arrest.

The outcome of these national initiatives, for which Dr Murphy has been substantially responsible and the main driver, has been a progressive increase in donation rates, attaining 49% since the Taskforce reported in 2008. Dr Murphy has transformed the experience of donating families and the lives of many transplant recipients. His impact on current and future patient care has been exceptional and is well worthy of the award of the Dudley Buxton Medal.

**Citation by Professor Julian Bion**

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Remotely assessed performance by peer review (RAPPeR)

Dear Editor,

I would like to commend to your readers a process developed locally which may help others in preparing for appraisal and revalidation. I have called it RAPPeR – Remotely Assessed Performance by Peer Review.

We, as do many hospitals, have a simulation suite in which can often be found such technology as mobile networked video cameras. We have utilised this technology to allow a peer group of senior anaesthetists to watch one of their colleagues in a clinical situation.

Live video, audio and patient monitor data are streamed from theatre to a remote location of choice allowing the peer group to evaluate performance against the four domains set out by the GMC in Good Medical Practice. Notes are taken and discussion between the peers is encouraged. Following the case, a debrief is conducted with the clinician who then writes a reflection. The notes and the reflection can be kept as evidence towards revalidation.

It is important to note that the video stream is not recorded and so there is no issue with information governance and written consent from the patient to be remotely observed is obtained.

It had occurred to me recently when filling out a 360 degree colleague questionnaire that I couldn’t really comment on their clinical decision making and treatment and whether they were up to date when, after nearly four years of being a consultant, I don’t think I had ever watched a consultant colleague give an anaesthetic outside the simulation suite.

As it happened, we had just begun to use remote observation for our core trainees, around the time of their assessment of basic competencies, in order to allow them some degree of freedom from immediate supervision but safe in the knowledge that a senior colleague was just around the corner, and it seemed like a natural progression that we should use the system for senior colleagues.

For revalidation, doctors will have to gather evidence of participation in activities that review and evaluate the quality of their work. The RCoA has given examples of these activities including: clinical audit, review of clinical outcomes, case review or discussion and review of significant events. I would like to recommend that RAPPeR be added to this list of examples.

Dr M Mackenzie, Consultant Anaesthetist, East Surrey Hospital

References


When I came to Savoy I saw the effect of the common drinking of snow water in Savoy. For there I saw many men and women have exceeding great bunches or swellings in their throates, such as we call in latin strumas, as bigge as the fistes of a man, through the drinking of snow water, yea some of their bunches were almost as great as an ordinary foote-ball with us in England. These swellings were much to be scene among these Savoyards, neyther are all the Pedemontanes free from them.

Here I will mention a thing that might have been spoken of before in discourse of the first Italian towne. I observed a custome in all those Italian Cities and Townes through the which I passed, that is not used in any other country that I saw in my travels, neither doe I thinke that any other nation of Christendome doth use it, but only Italy. The Italian and also most strangers that are commorant (ordinarily residing) in Italy, doe always at their meales use a little Forke when they cut their meat. For while with their feeding knife which they hold in one hand they cut the meat out of the dish, they fasten their forke which they hold in their other hand upon the same dish, so that whatsoever he be that sitting in the company of any others at meale, should unadvisedly touch the dish of meate with his fingers from which all at the table doe cut, he will give occasion of offence unto the company, as having transgressed the lawes of good manners, in so much as for his error he shall be at the least brow beaten, if not reprehended in wordes. This form of feeding I understand is generally used in all places of Italy, their forkes being for the most part made of yron or steele, and some of silver, but those are made only for Gentlemen.

The reason of this their curiosity is, because the Italian cannot by any means indure to have his dish touched with fingers, seeing all mens fingers are not alike clean. Hereupon I my selfe thought good to imitate the Italian fashion by this forked cutting of meate, not only while in Italy, but also in Germany, and oftentimes in England since I came home: being once quipped for the frequent using of my forke, by a certain learned Gentleman, a familiar friend of mine, one M Laurence Whitaker, who in his merry humour doubted not to call me at table fercifer, only for using a forke at feeding, but for no other cause.

Here I will mention a thing, that although perhaps it will seeme but frivolous to diverse readers that have already travelled in Italy: yet because unto many that neither have beene there, nor ever intend to go thither while they live, it will be a mere novelty, I will not let it passe unmentioned. The first Italian fannes I saw in Cremona. But afterwards I observed them common in most places in Italy where I travelled. These fannes both men and women of the country doe carry to cool themselves withal in the time of heate, by the often fanning of their faces. Most of them are very elegant and pretty things. For whereas the fanne consisteth of a painted peece of paper and a little wooden handle; the paper which is fastened into the top is on both sides curiously adorned with excellent pictures, either of amorous things tending to dalliance, having some witty Italian verses or fine emblems written under them; or of some notable Italian city with a briefe description thereof added thereunto. These fannes are of a meane price. For a man may buy one of the fairest of them for so much money as countervaileth our English groat.

Also many of them carry other fine things of a far greater price, that will cost at least a duckat, which they commonly call in the Italian tongue umbrellas, that is, things that minister shadow unto them for shelter against the scorching heate of the Sunne. These are made of leather something answerable to the form of a little canopy, and hooped in the inside with divers little wooden hoopes that extend the umbrella in a pretty large compasse. They are used especially by horsemen, who carry them in their hands when they ride, fastening the end of the handle upon one of their thighs, and they impart so long a shadow unto them, that it keepeth the heate of the sunne from the upperparts of their bodies.

From: Coryat’s crudities: hastily gobbled up in five months through France, Italy; etc (which can be downloaded free from www.archive.org).

Thomas Coryat (or Coryate, c1576–1617) was born in Crewkerne, Somerset, educated at Winchester and Oxford, and was one of the very early travellers through the continent of Europe. His ‘Crudities,’ published in 1611, described the tour he undertook in 1608. He is credited with introducing the fork into England, giving the first descriptions of the umbrella and the fan, and originating the idea of the Grand Tour. The urge to travel finally took him to India, where he died of dysentery in December 1617. His writings were very popular during the 17th and 18th centuries, and his description of the way bankrupts were dealt with in Padua has a lesson for today.

David Zuck
History of Anaesthesia Society
Report of Council

At a meeting of Council on Wednesday, 17 April 2013, Professor R Mahajan was re-admitted to Council and Dr J Fazackerley was admitted to Council following the election in December 2012.

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

**Regional Advisers**  
There were no appointments this month.

**Deputy Regional Advisers**  
There were no appointments this month.

**College Tutors**  

**Oxford**  
Dr N Beale, Churchill Hospital (acting Tutor for Dr D Choi)  
Dr M H J Size, Wycombe General Hospital (in succession to Dr C Nightingale)

**North Thames West**  
*Dr S P Kemp, Hammersmith/Queen Charlotte’s Hospitals  
*Dr T M Peters, West Middlesex University Hospital  
*Dr M A Stevens, Hillingdon Hospital

**North Thames Central**  
*Dr R L Simons, Royal Free Hospital

**North Thames East**  
Dr B Krishnachetty, Southend Hospital, Essex (in succession to Dr E Simpson)

**Mersey**  
Dr P A Burford, Southport and Ormskirk NHS Trust (in succession to Dr O S Kehinde)

**West of Scotland**  
*Dr D Smith, Glasgow Royal Infirmary

**South West Peninsula**  
*Dr J-A Thurlow, Musgrove Park Hospital

**Wales**  
Dr K M Woods, Royal Gwent Hospital  
(in succession to Dr T Sheraton)  
*Dr R Shobha, Glan Clwyd Hospital  
*Dr A G Ress, Withybush Hospital

**West Midlands North**  
*Dr C J De Klerk, Royal Shrewsbury Hospital

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

**Anglia**  
Dr Namita Arora  
Dr Aditi Modi

**North Central**  
Dr Kolitha Seneviratne

**Bart’s and The London**  
Dr Hardeep Chahal  
Dr Chiew Ng

**St George’s**  
Dr Christopher Jones  
Dr Suresh Anandakrishnan

**Mersey**  
Dr Sheila Carey

**North West**  
Dr Eva Campo-Garcia

**Northern**  
Dr David Snell  
Dr Thomas Haigh  
Dr Kiran Koneti

**Severn/Bristol**  
Dr Mark Migginton

**Tri-Services**  
Dr Deborah Easby *  
Dr Claire Park *  
Dr Stephen Lewis *

**Wessex**  
Dr Geoffrey Higenbottam  
Dr Duncan McPherson  
Dr Barnaby Kyle *

**Birmingham**  
Dr Rohit Mittal

**Stoke**  
Dr Jacquelyn Lewin  
Dr Jon Bingham

**South East Scotland**  
Dr Karen Stevenson

**South Yorkshire (Sheffield)**  
Dr Biju Charles

At a meeting of Council on Wednesday, 15 May 2013, Professor M Mythen was admitted to Council following the election in December 2012.

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

**Regional Advisers**  
There were no appointments this month.

**Deputy Regional Advisers**

**Anglia**  
Dr N A Barber, Addenbrooke’s Hospital  
(in succession to Dr H Hobbiger)

**Ministry of Defence**  
*Surgeon Commander K R E J Prior  
Lt Col P S Moor (in succession to Dr D Birt)

**College Tutors**  

**Anglia**  
Dr M M Bhagwat, The Norfolk and Norwich University Hospitals NHSFT  
(in succession to Dr C Sharpe)
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

North Central
Dr Nicholas Jenkins

Bart’s and The London
Dr Jayachandran Radhakrishnan

St George’s
Dr Lynda Menadue

Mersey
Dr Clare Hammell *

North West
Dr Simon Hellings *
Dr Sophie Bishop
Dr Aarti Shah

South West Peninsula
Dr Juliet Barker
Dr Zoe Brown

Tri-Services
Dr James Bradley

Birmingham
Dr Richard Pierson

Wales
Dr Vivekananda Joshi
Dr Sumit Jha

West Scotland
Dr Pamela Dean *
Dr Nitin Ahuja

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

Dr P Booker, Liverpool
Dr J D Crowson, Scarborough, North Yorkshire

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.
PROGRAMME OF EVENTS 2013

ADVANCED AIRWAY WORKSHOP
4 September 2013 (code: D43)
RCoA, London
Registration fee: £260 (£195 for RCoA registered trainees and affiliates)

JOINT INTENSIVE CARE SYMPOSIUM
(WITH THE FICM AND ICS)
4–5 September 2013 (code: C55)
RCoA, London
Registration fee: £455 (£335 for RCoA registered trainees and affiliates)

AFTER THE FINAL FRCA – MAKING THE MOST OF TRAINING YEARS 5 TO 7
5 September 2013 (code: B72)
RCoA, London
Registration fee: £165

CPD STUDY DAY: BURNS AND PLASTICS
9 September 2013 (code: C63)
RCoA, London
Registration fee: £200 (£150 for RCoA registered trainees and affiliates)

LEADERSHIP AND MANAGEMENT: PERSONAL EFFECTIVENESS
9 September 2013 (code: A71)
RCoA, London
Registration fee: £220

INTRODUCTION TO ACADEMIC ANAESTHETICS
9–10 September 2013
The London Deanery
Book online at: www.londondeanery.ac.uk

ADVANCED CENTRAL VENOUS ACCESS FOR ANAESTHETISTS
13 September 2013 (code: F35)
RCoA, London
Registration fee: £240 (£180 for RCoA registered trainees and affiliates)

ASSOCIATION OF CARDIOTHORACIC ANAESTHETISTS ACADEMY DAY
16 September 2013
RCoA, London
Registration fee: £100 (£70 for RCoA registered trainees and affiliates)
See ACTA website (www.acta.org.uk) for more information.

ANAESTHETISTS AS EDUCATORS: TEACHING AND TRAINING IN THE WORKPLACE
16–17 September 2013 (code: A37)
RCoA, London
Registration fee: £425 (£320 for RCoA registered trainees and affiliates)

ULTRASOUND WORKSHOP
17 September 2013 (code: D09)
RCoA, London
Registration fee: £240 (£180 for RCoA registered trainees and affiliates)

CHILDREN IN THE DISTRICT HOSPITAL: ESSENTIAL CARE
20 September 2013 (code: D95)
RCoA, London
Registration fee: £200 (£150 for RCoA registered trainees and affiliates)

CPD STUDY DAYS
23–24 September 2013 (code: A99)
RCoA, London
Registration fee: £355 (£265 for RCoA registered trainees and affiliates)

AIRWAY LEAD DAY
26 September 2013
RCoA, London
Registration fee: £125

UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE (LONDON)
26–27 September 2013 (code: D29)
RCoA, London
Registration fee: £450

NIAA RESEARCH WEEK
30 September – 3 October 2013
See page 63 for full listing

CPD STUDY DAY (BELFAST)
2 October 2013 (code: C97)
The Waterfront Hall, Belfast
Registration fee: £200 (£150 for RCoA registered trainees and affiliates)

UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE (BATH)
3–4 October 2013 (code: D93)
Education Centre, Royal United Hospital
Registration fee: £450

AIRWAY WORKSHOP (GLASGOW)
9 October 2013
IET Glasgow: Teacher Building
Registration fee: £260 (£195 for RCoA registered trainees and affiliates)

JUBILEE CURRENT CONCEPTS SYMPOSIUM: RISING STARS IN ANAESTHESIA
10–11 October 2013 (code: B05)
RCoA, London
Registration fee: £445 (£335 for RCoA registered trainees and affiliates)

CONTINUING PROFESSIONAL DEVELOPMENT DAY
12 October 2013 (code: A76)
RCoA, London
Registration fee: £240 (£180 for RCoA registered trainees and affiliates)

REDUCED RATE
A reduced rate of £565 (£425 for RCoA registered trainees and affiliates) is available for those attending both the Jubilee current concepts symposium and the Continuing professional development day. (Code D53)

Places for the events will be offered on a first come, first served basis.
THE EVENTS DEPARTMENT | events@rcoa.ac.uk  ❯ 020 7092 1673  ❯ www.rcoa.ac.uk/events

A CAREER IN ANAESTHESIA
21 October 2013 (code: D08)
Rose Bowl, Leeds
Registration fee: £45

PATIENT SAFETY CONFERENCE
23 October 2013 (code: CO3)
Cardiff City Hall
Registration fee: £215

A CAREER IN ANAESTHESIA
29 October 2013 (code: C49)
RCoA, London
Registration fee: £45

UK TRAINING IN EMERGENCY AIRWAY MANAGEMENT (TEAM) COURSE (EDINBURGH)
5–6 November 2013 (code: B75)
Edinburgh Royal Infirmary
Registration fee: £450

JOINT CLINICAL DIRECTORS MEETING (WITH THE AAGBI)
13 November 2013
RCoA, London
By invitation only

ANAESTHETISTS AS EDUCATORS: AN INTRODUCTION
18 November 2013 (code: A12)
RCoA, London
Registration fee: £220 (£165 for RCoA registered trainees and affiliates)

AIRWAY WORKSHOP
20 November 2013 (code: C65)
RCoA, London
Registration fee: £260 (£195 for RCoA registered trainees and affiliates)

FACULTY OF PAIN MEDICINE ANNUAL MEETING
22 November 2013 (code: B08)
RCoA, London
Registration fee: £185 (£135 for RCoA registered trainees and affiliates)

CPD STUDY DAY
26 November 2013 (code: C79)
RCoA, London
Registration fee: £200 (£150 for RCoA registered trainees and affiliates)

JOINT RSM/RCoA EVENT – EMERGENCIES
29 November 2013
Royal Society of Medicine, London
Registration fee: TBC

LEADERSHIP AND MANAGEMENT: WORKING WELL IN TEAMS...AND MAKING AN IMPACT
3 December 2013 (code: A93)
RCoA, London
Registration fee: £220

RECENT ADVANCES IN ANAESTHESIA CRITICAL CARE AND PAIN MANAGEMENT
3–5 December 2013 (code: C11)
Crowne Plaza, Nottingham
Registration fee: £490

ANAESTHETISTS AS EDUCATORS: TEACHING AND TRAINING IN THE WORKPLACE
4–5 December 2013 (code: C80)
RCoA, London
Registration fee: £425 (£320 for RCoA registered trainees and affiliates)

ANAESTHETISTS AS EDUCATORS: TEACHING AND TRAINING IN THE WORKPLACE

Day 1
9.45–10.15 am
Registration and refreshments

SESSION 1: WELCOME AND COURSE INTRODUCTION
Personal learning objectives (small groups)

SESSION 2: LEARNING AND TEACHING
Learning theories (plenary)
Learning styles (small groups)

SESSION 3: FEEDBACK: THE FUEL TO DRIVE PERFORMANCE
Feedback (plenary)
Feedback (small groups)

SESSION 4: WORKPLACE TEACHING – PLANNING
Planning learning (plenary)
Planning learning (small groups)
5.15 pm
Wrap of day one

DRINKS RECEPTION FOR ALL

Day 2
8.00–8.30 am
Registration and refreshments

SESSION 5: WORKPLACE TEACHING: SKILLS TEACHING
Workplace teaching (plenary)
Workplace teaching (small groups)

SESSION 6: WORKPLACE ASSESSMENT
Assessment of professionals (plenary)

SESSION 7: PRACTICE TEACHING

SESSION 8: WRAP UP
Practice teaching debrief with refreshments
Wrap up and close (whole group)

TIMINGS MAY BE SUBJECT TO CHANGE

CPD Matrix codes
JOINT INTENSIVE CARE SYMPOSIUM

Date and venue:
4–5 September 2013 (code: C55)
RCoA, London

Registration fee:
£445 (£335 for RCoA registered trainees and affiliates)
Approved for 10 CPD credits

Event organiser:
Dr J Goodall and Professor T Evans

DAY 1

SESSION 1: CARDIOLOGY UPDATE
- Grown up congenital heart disease: how to manage the unstable patient?
  Dr A T Lovell, Bristol
- Do we fail the failing heart?
  Professor T McDonagh, London
- Dysrhythmias: dispelling the myths
  Professor R Schilling, London

SESSION 2: CHANGING TIMES – CHANGING ICM
The implications for ICU of:
- An ageing population
  Professor F Martin, London
- Major surgery: when do we need ICU?
  Dr R Pearse, London
- Obesity and ICM: problems with extremes of body habitus
  Professor N Finer, London

SESSION 3: HOW I ...
- Manage resistant infections in the ICU
  Dr D Jenkins, Leicester
- Manage the injured spinal cord
  Dr J McKinlay, Leeds
- Investigate brain injury on the ICU
  Professor D Menon, Cambridge

SESSION 4: BURNOUT IN ICU
- Burnout – what burnout?
  Dr J Goodall, Manchester
- Sources of occupational stress in ICM
  Dr P Alexander, Manchester
- A suitable job for a woman?
  Dr R Haslett, Salford

DAY 2

SESSION 5: DO WE STILL NEED TO WORRY ABOUT ...
- Tight glycaemic control
  Dr J Cordingley, Brompton
- What fluid to use
  Dr A Rhodes, London
- Surviving sepsis
  Dr R Beale, London
- Low tidal volume ventilation
  Dr D Macauley, Belfast

SESSION 6: A CAREER IN ICM
- The role of the Faculty (education and training)
  Dr S Baudouin, Newcastle
- Career advice
  Dr J Goodall, Manchester
- Trainees survey
  Dr C Booth, Salford

SESSION 7: WHAT’S NEW IN ICU
- In renal medicine
  Dr M Ostermann, London
- In imaging
  Dr S Desai, London
- In paediatrics
  Dr D McCrae, London
- The national ECMO service
  Dr S Finney, London

SESSION 8: LAW AND ETHICS
- Reliability of the expert witness
  Dr C Danbury, Berkshire
- An acute legal service for ICM
  Dr A Eyon, Southampton
A CAREER IN ANAESTHESIA

Date and venue:
21 October 2013 (code: D08)
Rose Bowl, Leeds
29 October 2013 (code: C49)
RCoA, London

Registration fee:
£45

The Royal College of Anaesthetists is holding an informal session for Foundation Year Two Trainees who are considering a career in anaesthesia. This half day session to be held at the Rose Bowl, Leeds, has been produced due to popular demand for the event to be taken regionally. The same programme will run the following week at the RCoA as two half-day sessions.

The Career in Anaesthesia day is not intended to provide personal career guidance, but instead will focus on the general aspects of the specialty. It will provide an insight into life as a trainee and consultant anaesthetist. There will also be plenty of time for questions.

- Welcome
- Introduction
- Life as an anaesthetic trainee
- Assessment and supervision of training
- Recruitment and application process
- Academic anaesthesia
- ITU
- Question and answer group sessions (including refreshments)
- The future in the specialty, skills required and life as a consultant

LEADERSHIP AND MANAGEMENT FOR ANAESTHETISTS

Venue:
RCoA, London

Four interactive workshops designed specifically for anaesthetists.

The workshops are a balance of plenary sessions, group work and exercises with the emphasis on real life issues, open discussion, up to date information and specific time for one to one discussions where requested. Attendance at all four workshops will provide you with:

- A sound knowledge of past and current NHS Policy
- A good insight into personal development needs and the opportunity to construct a Personal Development Plan
- An introduction to negotiation and influencing tools and skills
- An understanding of how to effect change
- And more

Leadership and management: personal effectiveness
9 September 2013 (code: A71)
Registration fee: £220

Leadership and management: working well in teams and making an impact!
3 December 2013 (code: A93)
Registration fee: £220

Leadership and management: leading and managing change; success with service development
11 March 2014 (code: C41)
Registration fee: £220

Introduction to leadership and management for anaesthetists: the essentials
29–30 May 2014 (code: B56)
Registration fee: £445
ADVANCED CENTRAL VENOUS ACCESS FOR ANAESTHETISTS

Date and venue: 13 September 2013 (code: F35) RCoA, London
Registration fee: £240 (£180 for RCoA registered trainees and affiliates) Approved for 5 CPD credits
Event organisers: Dr A Bodenham and Dr A Johnston

This day is designed for consultants and senior trainees who have mastered the usual elements of short term venous access but would like to extend their knowledge and repertoire of other procedures. There will be discussion of both adult and paediatric practice.

The day consists of didactic lectures and smaller group teaching on skills stations. The faculty includes adult and paediatric anaesthetists/ intensivists and vascular radiologist.

- **10.00–10.20 am**
  Registration and refreshments

- **Introduction**
  Dr A Bodenham, Leeds

- **Choice of devices, patient assessment, sedation/LA/GA?**
  Dr H McLure, Leeds

- **Insertion of PICCs, Hickmans, Ports**
  Dr A Johnston, Cambridge
  How we do it (three short videos)

- **Catheter tip positioning**
  Dr A Bodenham, Leeds

- **Central venous access in the very small child**
  Dr J Bennett, Birmingham

- **Common problems**
  - Blocked catheter management
  - Fibrin sleeves, mechanical blockage, fibrinolytics
  Dr A Johnston, Cambridge

- **Rotational workshops will feature during the event:**
  Ultrasound/x-ray/surgical skills/radiology/trade stands
  Which cases should be referred to radiology?
  - Assessment of central vein blockage on incidental/booked CT, on table venography, ultrasound
  - Other practical tips from radiology
  - Stenting/complication management
  Dr T Choon See, Cambridge

- **Final discussion and questions**

- **4.30 pm**
  Close of event

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CHILDREN IN THE DISTRICT HOSPITAL: ESSENTIAL CARE

Date and venue: 20 September 2013 (code: D95) RCoA, London
Registration fee: £200 (£150 for RCoA registered trainees and affiliates) Approved for 5 CPD credits
Event organisers: Dr M Tremlett

- **8.30–9.00 am**
  Registration and refreshments

- **Introduction and welcome**
  Dr M Tremlett, Middlesbrough

- **Management of the serious medical illness (2D01)**
  Dr M Entwistle, Lancaster

- **Management of the serious surgical illness including transfer (2D01)**
  Dr P Murphy, Liverpool

**WORKSHOPS**

Groups will rotate around the four workshops:

- **Cases of consent (1F01)**
  Dr A MacLeod, London

- **The anxious child (2D02)**
  Dr R Martin, London

- **The children’s difficult intubation trolley (2A01, 2D03)**
  Dr P Stoddard, Bristol

- **What kit do you need for transfers? (2A11, 2D07)**
  Speaker to be advised

- **Which regional blocks matter? (2D02)**
  Dr A Aziz, Middlesbrough

- **Pain relief at home (2D05)**
  Dr G Williams, London

- **4.30 pm**
  Close of event
JUBILEE CURRENT CONCEPTS SYMPOSIUM 2013:
RISING STARS IN ANAESTHESIA AND CRITICAL CARE

Date and venue:
10–11 October 2013 (code: B05)
RCoA, London

Registration fee:
£445 (£335 for RCoA registered trainees and affiliates)
Approved for 10 CPD credits

Event organisers:
Dr R Moonesinghe and Dr S Gulati

DAY 1

SESSION 1: PAIN AND REGIONAL ANAESTHESIA
- Persistent post-operative pain: mechanisms and prevention (3E00)
  Dr S Anwar, London
- Neuropathic pain in the peri-operative period (3E01, 3E00)
  Dr B Frank, Liverpool
- Pain: do we need new drugs or new receptors (3E00)
  Dr R Cregg, London

SESSION 2: MANAGEMENT, TRAINING AND RESEARCH
- Measuring and reporting quality of anaesthesia care: performance polygons (1I05)
  Dr M Coupe, Bath
- Training for trauma (2A02, 3J00)
  Dr S Mercer, Liverpool

SESSION 3: MEASUREMENT AND MONITORING
- Measuring cardiac output to improve surgical outcome (2A04)
  Dr M Cecconi, London
- Depth of anaesthesia, sedation: what does fMRI tell us? (2A04)
  Dr N Saxena, Cardiff

SESSION 4: SURGICAL OUTCOME
- Neurological outcome after non-cardiac surgery (3I00)
  Dr R Sanders
- Wheel of fortune – exercise testing and colorectal surgery (2A03)
  Dr G Minto, Plymouth and Dr Harris, London

SAMUEL THOMPSON ROWLING LECTURE ORATION
- Monitoring cerebral blood flow (2A04)
  Professor C Hogue, USA

SESSION 5: CRITICAL CARE
- Genomics and critical illness (2A12)
  Dr K Baillie, Edinburgh
- Epidemiology of critical illness in UK hospitals (3C00)
  Dr S Harris, London
- Sepsis related immunosuppression and risk modelling
  Dr M Morgan, Wales

SESSION 6: AIRWAYS
- Implementation of NAP4 in a DGH (2A01, 3A01)
  Dr F Kelly, Bath
- Laryngoscopy and laryngoscopes – time to rethink the paradigm (2A01, 3A01)
  Dr E O’Sullivan, Ireland

SESSION 7: LEADERSHIP AND ORGANISATION
- 1.30 pm
  Presentation of College Prizes
- Medical management of the London 2012 olympics (1I02, 3J00)
  Dr D Zideman, London
- Research at altitude vs implementing enhanced recovery – which is easier?! (3J00)
  Dr D Martin, London

SESSION 8: OBSTETRICS
- Blood conservation strategy in obstetric anaesthesia and use of technology in obstetric anaesthesia (3B00)
  Drs C Chevannes, D Castillo and C Bearton
- Use of technology in obstetric anaesthesia
  Speaker to be advised

- 4.45 pm
  Close of event

PROGRAMME SESSIONS AND LECTURE TOPICS ARE SUBJECT TO CHANGE.

REDUCED RATE
A reduced rate of £565 (£425 for RCoA registered trainees and affiliates) is available for those attending both the Jubilee current concepts symposium and the Continuing professional development day (code D53). Places for the events will be offered on a first come, first served basis.
CONTINUING PROFESSIONAL DEVELOPMENT (CPD) DAY 2013

Date and venue: 12 October 2013 (code: A76)
RCoA, London

Registration fee: £240 (£180 for RCoA registered trainees and affiliates)
Applied for 5 CPD credits

Event organiser: Dr J Nolan

REDUCED RATE
A reduced rate of £565 (£425 for RCoA registered trainees and affiliates) is available for those attending both the Jubilee current concepts symposium and the Continuing professional development day. (Code: D53)
Places for the events will be offered on a first come, first served basis.

<table>
<thead>
<tr>
<th>SESSION 1: CLINICAL PRACTICE 1</th>
<th>SESSION 2: CLINICAL PRACTICE 2</th>
<th>SESSION 3: RECENT ADVANCES</th>
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</thead>
<tbody>
<tr>
<td><strong>1A</strong> Enhanced recovery for colorectal surgery (2A07) Dr M Scott, Guildford</td>
<td><strong>1B</strong> CICV – be prepared (2D01) Dr T Cook, Bath</td>
<td><strong>1C</strong> Preoperative risk stratification (3A19) Dr M Thomas, Bristol</td>
</tr>
<tr>
<td><strong>2A</strong> Anaesthesia for the obese patient (3A08) Dr C Nightingale, Buckinghamshire</td>
<td><strong>2B</strong> Paediatric emergencies in the DGH (2A04) Dr R Beringer, Bristol</td>
<td><strong>2C</strong> β-blockers, statins and stents in peri-operative care (3A18) Professor P Foëx, Oxford</td>
</tr>
<tr>
<td><strong>3A</strong> Acute pain management (2E01, 3A09) Dr B Fischer, Redditch</td>
<td><strong>3B</strong> Fluids: what’s in and what’s out (2G03) Dr J Nolan, Bath</td>
<td><strong>3C</strong> Monitoring depth of anaesthesia (2G02, 3A09) Dr A Nimmo, Edinburgh</td>
</tr>
</tbody>
</table>

| SESSION 4: CRITICAL INCIDENTS | SESSION 5: QUALITY | SESSION 6: ANAESTHETIC MANAGEMENT |
|-------------------------------|-------------------|---------------------------------
| **4A** Accidental awareness during general anaesthesia (3A19) Professor J Hardman, Nottingham | **4B** Anaphylaxis Dr N Harper, Manchester | **4C** Root cause analysis of major incidents Professor R Mahajan, Nottingham |
| **5A** High risk surgical patients: a quality improvement approach (2F01) Speaker to be advised | **5B** Quality improvement indicators for anaesthetists (3A21) Speaker to be advised | **5C** 25 years of NCEPOD (3A02, 3A10) Dr A Goodwin, Bath |
| **6A** Regional anaesthesia: an update (2G01, 3A09) Dr B Nicholls, Taunton | **6B** Management of the obese obstetric patient (2B01, 2B04) Dr N Lucas, Middlesex | **6C** Airway management in trauma patients (2A01) Dr D Lockey, Bristol |

- 9.00–9.25 am
  - Registration
  - Introduction for all delegates
    - Dr J-P van Besouw, President, RCoA

- 3.35 pm
  - Close of event

PROGRAMME IS SUBJECT TO CHANGE
NIAA RESEARCH WEEK

30 September 2013 to 3 October 2013

Join us for all or part of our Research Week, which includes:

- **30 September 2013**
  BJA Research Methodology Workshop (code: C43)
  Registration fee: £150

- **1 October 2013**
  BJA Peer Reviewers’ Workshop (am) (code: F96)
  Registration fee: Free
  ARS Meeting Day 1 (pm)
  See ARS website (www.ars.ac.uk)

- **2 October 2013**
  ARS Meeting Day 2 including poster presentations and President’s Prize for Undergraduate Research
  ARS Social Dinner

- **3 October 2013**
  HSRC UK Peri-operative Clinical Research Forum (code: B13)
  Registration fee: £45

For more programme information, please go to: www.niaa.org.uk/EventsCalendar

RECENT ADVANCES IN ANAESTHESIA, CRITICAL CARE AND PAIN MANAGEMENT

Date and venue:
3–5 December 2013 (code: C11)
Crowne Plaza, Nottingham

Registration fee:
£490
Applied for 15 CPD credits

Event organisers:
Dr R Verma and Dr J Williams

DAY 1
- Welcome and introduction
- Mechanisms of action of anaesthesia
- Recent advances in opioid analgesic agents
- Cannabinoid analgesic agents
- Anaesthesia for hip fractures
- Orthogeriatric risk assessment
- Number needed to treat or prospect
- Risk prediction in anaesthesia

DAY 2
- Epigenetics of anaesthesia
- Carbohydrate loading in the peri-operative period
- Simulation training
- Simulation in research
- Neural toxicity of anaesthetics
- Opiates and long-term outcome
- Validity of consent in anaesthesia
- Wildlife anaesthesia

DAY 3
- Beyond 2D ultrasound
- Neuroanaesthesia monitoring
- Findings from EuSOS
- National Audit Project 5
- Recent advances in peri-operative acute kidney injury
- NICE fluid resuscitation guidelines
- Optimal cardiac output monitoring

CPD STUDY DAY, BELFAST

Date and venue:
2 October 2013 (code: C97)
Belfast, Waterfront

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

Event organiser:
Dr B Darling

8.30–9.00 am
Registration and refreshments

- Awake craniotomy
- Interventional neuroradiology
- Neuro critical care
- CPD and revalidation
- Trainee prize giving
- RA techniques
- Children and consent
- Fluid administration in children
- This house believes that guidelines spell the death of professionalism

Trainee presentation competition

The closing date for abstract submission is 31 August 2013.

To enter the competition, please visit the RCoA Events page (www.rcoa.ac.uk/education-and-events) where more information on how to apply is available. Abstracts for presentation will be selected by the judges prior to the meeting.
Lives of the Fellows

Archiving photographs
The RCoA has a large collection of unidentified old photographs from the time we resided in the RCS and we are asking for your assistance in naming people in them. If you recognise anyone from the photographs below then please inform Ben Hedley, our archivist, at bhedley@rcoa.ac.uk.

We received some conflicting naming suggestions for the photograph that was included in Bulletin 78 (below) but our best guess is: (L-R) Dr Archibald D Marston CBE (Dean 1948–1952), Guest (?), Dr Frankis T Evans (Dean 1955–1958), Guest (?), Guest (?), Dr John Gillies.

Thanks to Professor Barry Baker, Dr Dickie Fairer and Dr John Francis for their assistance.

The Facing Africa Anaesthetic Fellowship
The Facing Africa Anaesthetic Fellowship is a new venture between the Royal College of Anaesthetists and Facing Africa, a UK-based charity. We are seeking suitable UK trainees to apply for this Fellowship, providing funds for travel and accommodation.

The Fellow will join the team this October for two weeks. Consultant anaesthetists, surgeons and nurses travel and work as a team providing free reconstructive facial surgery for noma survivors.

Noma (Cancrum Oris) is a devastating disease of malnutrition, mostly afflicting children with rapid necrosis of mouth and midface and high mortality. Survivors suffer extensive facial disfigurement. Noma patients have difficult airways, with trismus and restricted tissue mobility of mouth and midface. Tracheal intubation with fibreoptics or videolaryngoscopy are usually selected for airway control. Equipment available includes fibreoptic bronchoscopes, videolaryngoscopes, optical stylet and ‘front of neck’ equipment (retrograde, narrow – and wide-bore cricothyroidotomy devices including Ventrain). Full supervision and training is given.

This is a great opportunity for the appointed Fellow to learn advanced airway techniques with the Facing Africa team. These skills are transferable to UK difficult airway practice and there is ample scope for research.

If you are interested in applying please contact Dr David Ball at dball@nhs.net. You will also find more information at www.facingafrica.org.

Closing date for application: 1 August 2013.
CJD Incidents Panel dissolved

From 1 April 2013 the responsibility for investigating, assessing and managing CJD incidents will be with local trusts, health boards and health protection teams in the same way as most other incidents that place patients at risk.

- National guidance on CJD incident management will be available to support this and is published on the Health Protection Agency website at: www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/CreutzfeldtJakobDisease/CJDGuidanceAndAdvice/.
- Novel issues that arise with respect to CJD risk management and infection control can be referred to the Advisory Committee on Dangerous Pathogens (ACDP) Transmissible Spongiform Encephalopathy (TSE) Risk Management Sub-Group.
- Long-term public health surveillance of CJD exposures will continue and trusts, health boards and health protection teams are asked to continue reporting the occurrence of incidents to PHE, in particular if they involve a patient notification exercise.
- Infection control guidance from the Advisory Committee on Dangerous Pathogens Transmissible Spongiform Encephalopathy Risk Management Sub-Group (ACDP TSE RM SG – formerly the TSE Working Group) to reduce the risk of the spread of TSEs in healthcare and community settings can be found at: www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group.

Further/background information

What is a CJD incident? – A surgical incident has occurred when a patient with or at increased risk of CJD has had an invasive procedure involving high or medium infectivity tissues for CJD and TSE instrument precautions were not taken. Patients subsequently exposed to the implicated instruments may need to be informed that they are at increased risk of CJD, depending on the specific circumstances.

Questions relating to the interpretation of the guidance should be sent to the HPA/PHE CJD team either via the CJD mailbox at: cjd@phe.gov.uk or to:

KatySinka
katy.sinka@phe.gov.uk
020 8327 6411

EmmaHollis
emma.hollis@phe.gov.uk
020 8327 6406

The RCoA Bulletin is published bi-monthly and distributed to over 15,000 anaesthetists worldwide, the vast majority being in the UK. Being so widely distributed, it is obviously seen by many other professionals who work alongside anaesthetists. Advertisements for courses and meetings from anaesthetic societies, or those organisations that are of interest to anaesthetists, are accepted with prior approval of the Editor or Editorial Board.

Advertisements must fit with the aims and aspirations of the RCoA and be related to anaesthesia, critical care and pain medicine. Please contact bulletin@rcoa.ac.uk for separate commercial advertising rates.

Rates below are valid from 1 July 2013 to 30 June 2014:

- Quarter page (85 mm by 124 mm) £270 +VAT
- Half page (85 mm by 252 mm) £535 +VAT
- Full page (175 mm by 252 mm) £855 +VAT

Please go to www.rcoa.ac.uk/node/461 to complete the necessary Terms and Conditions of Business and to submit your advert.
Please see below consultations that the Royal College of Anaesthetists has responded to in the last two months.

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<td>Consultation on Critical Care Position Paper and Tracheostomy competencies</td>
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<td>European Board of Anaesthesiology (UEMS)</td>
<td>Feedback on the SETQ (Systematic Evaluation of Teaching Qualities of Trainers)</td>
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<td>Department of Health</td>
<td>Consultation on implementation of Directive 2011/24/EU on patients’ rights in cross-border healthcare</td>
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<td>Hereditary Angioedema Patient Association UK/UK Primary Immunodeficiency Network</td>
<td>Update of UK C1 inhibitor deficiency consensus</td>
</tr>
<tr>
<td>Academy of Medical Royal Colleges</td>
<td>Contribution to the Intercollegiate work on the Academy’s Draft Action Plan following the Francis Report</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence (NICE)</td>
<td>Surgical Site Infection Quality Standard</td>
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</table>

To celebrate the 65th Anniversary of the NHS, the Royal College of Anaesthetists has produced a short film to highlight developments in the specialty over the last six decades. Since the inception of the NHS, anaesthesia has changed significantly, and our short film will mark significant developments in anaesthesia from 1948 to present time through a series of short interviews with our Fellows.

The video and accompanying article will be launched shortly and will be available on the College’s website (www.rcoa.ac.uk).

Watch this space!

Appointment of Members, Associate Members and Associate Fellows

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

**Associate Fellows**
- Dr Balazs Kovacs
- Dr Michal John Fried
- Dr Biswajit Das
- Dr Elonka Maria Theodora Elisabeth Bergmans

**Members**
- Dr Mohamed Samy Abd Ellatif
- Dr Elizabeth Jane Carson

**Associate Members**
- Dr Hind Saeed El-Mahdi
- Dr Aleem Ahmad Khan

**Affiliate – Veterinary**
- Dr Evodokia Psatha

**Affiliate – Physicians’ Assistant (Anaesthesia)**
- Miss Gemma Muse

Appointment of Fellows to consultant and similar posts

The College congratulates the following Fellows on their consultant appointments:

- Dr A Basavaraju, Western Infirmary, Glasgow
- Dr S Bishop, University Hospital of South Manchester
- Dr C Blandford, Torbay Hospital
- Dr J Campbell, Queen Charlotte’s and Chelsea Hospital, London
- Dr C L Park, King’s College Hospital, London
- Dr R Pierson, Dudley Group NHS Foundation Trust
CPD system registers its 5,000th user

We are delighted to announce that the number of users for the College CPD system has reached 5,000. Dr Mark Kubli, Consultant Anaesthetist at the Ashford and St Peter’s NHS Foundation Trust, became the 5,000th registered user and commented: ‘With Revalidation now upon us it is a worthy time to organise, count CPD and possibly have a rough estimate of where we are pitched in passing the mighty “Relicensing” procedure from the GMC.’

As a local appraiser in his trust, Dr Kubli says that he has seen ‘a spectrum of submissions from the crème de la crème efforts to walking the razor sharp knife edge of the minimalists approach’ and he emphasises the importance of documented evidence as forming a considerable part of a doctor’s portfolio.

The online CPD system enables doctors to add and reflect upon their completed CPD activities which information can be uploaded into a PDF report and Dr Kubli says: ‘Accessing the swish RCoA online CPD system on initial attempts proved to be a “Bonza” experience. Easy, quick, reliable first touch clicking was a delight to engage. Well done to the RCoA for belting out this little number!’

To register and access go to: www.cpd.rcoa.ac.uk

SAFE ANAESTHESIA LIAISON GROUP
Patient Safety Conference
23 October 2013, Cardiff
Approved for 5 CPD Points
Fee: £210
Opening address from Dr Chris Jones, Deputy CMO Wales
Topics will include:
Never Events | Crisis Checklists
Poorly Performing Anaesthetists
Role of the Anaesthetist in Surgical Safety
M&M Toolkit Launch
Team Training
Information: SALG@rcoa.ac.uk or 020 7092 1574
Picture credit: www.visitcardiff.com

ACTA Academy
16 September 2013
The Royal College of Anaesthetists, London
Morning lectures
■ Management of bleeding following cardiac surgery
■ Vasoactive drugs and their use in cardiac anaesthesia
■ Principles and practice of cardiopulmonary bypass
■ Human factors in cardiac anaesthesia and surgery
■ Early complication of cardiac surgery
■ Practical Thoracic Anaesthesia
Afternoon workshops
■ Cardiac output monitoring and fluid management
■ ECMO simulator
■ Orpheus Bypass Simulator
■ Echocardiography simulator
■ Thoracic anaesthesia workshop
The day is mapped to Level 3 CPD and the CCT in Anaesthesia and aimed at FRCA candidates, trainees with an interest in cardiothoracic anaesthesia and for Consultant CPD
Organisers: Dr Dom Spray and Dr Nick Fletcher
Fee: £100 (trainees £70) RCoA CPD points applied for
Book and pay at: www.acta.org.uk/home/training.asp
Contact: cbunnell@rcoa.ac.uk
**PRIMARY FRCA OSCE/SOE COURSE**

21–22 October 2013
23–24 October 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: £100
Breakfast, lunch & refreshments are included

For further details please visit our website
www.anaesthetics.uk.com
Or contact:
renata.czarnecka@uhcw.nhs.uk
024 7696 8722

**COVENTRY PRIMARY FRCA MCQ/SBA COURSE**

27–29 August 2013
14–16 October 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:
renata.czarnecka@uhcw.nhs.uk
024 7696 8722
www.anaesthetics.uk.com

**COVENTRY AIRWAY MANAGEMENT COURSE**

8 October 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

Approved for 5 CPD credits
(1H02, 1B02, 1C01, 1C02, 2A01, 3A01)
from the RCoA

Registration fee: £95
includes refreshments and lunch
For further details please contact:
renata.czarnecka@uhcw.nhs.uk
024 7696 8722
www.anaesthetics.uk.com

**FINAL FRCA MCQ/SAQ COURSE**

19–21 August 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 two months prior to the course.

Registration fee: £260
Includes a copy of SOE in clinical anaesthesia book, breakfast, lunch and refreshments

For further details please contact Gillian Prior
coventryanaesthetics@live.co.uk
024 7696 7083
www.anaesthetics.uk.com or www.mededcoventry.com
Dingle 2013
3rd Joint Meeting of the 15th Current Controversies in Anaesthesia & Peri-Operative Medicine and Intensive Care Society of Ireland Autumn Meeting

Dingle, Co. Kerry, Ireland
25th-29th September 2013

Call for Abstracts
€1000 in Prizes

- Anaesthesia and Pain Abstract Prize
- Critical Care (research or clinical practice) Abstract Prize
- Kate Flynn Prize for Critical Care Case History Abstract

Any research is acceptable provided it has not been published in peer reviewed journal by the abstract deadline of 7th July 2013.

Trainees with abstract accepted for poster presentation are entitled to a £50 discount on registration and an additional £50 discount if also accepted for oral presentation. All presenters, both poster & oral, must register for the conference to present their work.

EBPOM
Regional Meetings 2013/2014

Exeter
- EBPOM Regional Meeting, 5th September 2013

Newcastle
- EBPOM Regional Meeting, 29th November 2013
- 9th Perioperative CPET Course, 27th & 28th Nov 2013

Manchester
- EBPOM Regional Meeting, 28th February 2014

Full details and booking at www ebpom org.
State of the Art Meeting 2013
Mon 16 to Wed 18 December 2013
The ICC, East ExCeL, London

The UK's largest meeting for Intensive Care Professionals

Key Note Speakers:
Prof Pat Croskerry, Canada
Prof Daniel De Backer, Belgium
Prof Jan De Waele, Belgium
Prof Monty Mythen, UK
Prof Mervyn Singer, UK
Prof Arthur Slutsky, Canada
Prof Jukka Takala, Switzerland
Prof Brian Toft, UK
Prof Roger Watson, UK
Prof. Ingeborg Weiters, UK, Germany

Topics:

Also featuring:

Rates frozen from 2012 Early Bird registration available before the 30/09/13*
*full fee breakdown available on the ICS website

CPD Accreditation: 15 points pending

@ICSMeetings
www.ics.ac.uk

The Preoperative Association 2013 National Conference
7th November 2013
York Racecourse
York

Topics to include:
Assessment of the Elderly Patient; Challenges of the Obese Patient; Chronic Pain and Pre-operative Assessment; Anti-platelet Therapy Update; CPET Workshop; Calculating Peri-operative Risk; Who Needs Critical Care Admission?

Accredited with 5 CPD Points

Abstract for presentations or posters to be submitted by 30th September 2013
Open to all healthcare professionals involved in the preoperative assessment of the surgical patient.

For full details and to book your place, please visit www.pre-op.org or call 020 7631 8896
SPECIAL ANNOUNCEMENT # 1
Primary FRCA OSCE/SOE Examination
November 2013

The MSA OSCE/Orals Courses
In view of the fact that a significant number of trainees now only require one element of the Examination, this course is split into an OSCE Component followed by an SOE Component.

Full Course: 2.00 pm Friday, 25 October to 4.00 pm Friday, 1 November (Course Fee: £600)
OSCE Course: 2.00 pm Friday, 25 October to 12.00 noon Tuesday, 29 October (Course Fee: £300)
SOE Course: 2.00 pm Tuesday, 29 October to 4.00 pm Friday, 1 November (Course Fee: £300)
Trainees may apply for either or both courses.
Places are limited as detailed on the website

SPECIAL ANNOUNCEMENT # 2
Final FRCA or FCAI Examination
Spring 2014

The SAQ and E&SAQ Writers Club
Preparation and Practice
The One-Off Writers Club Membership Fee is £400
Members remain Members at No Further Charge until successful
Members are entitled to attend the SAQ Weekend Courses Free of Charge
Members are entitled to attend the Private Members Only SAQ Weekend Free of Charge
The only requirement asked of members is Commitment to the Discipline
Trainees should consider Joining the Club Sooner than Later
The More Practice, the Better
The Greater the Accumulation of Answer Sheets

SPECIAL ANNOUNCEMENT # 3
Primary and Final FRCA or FCAI Examinations
2013/2014

MCQ/SBA Faculty Membership
Trainees preparing for these examinations are invited to apply for
Membership of the Primary or Final MCQ/SBA Faculty
Discipline – Application – Revision
No Charge other than Commitment

All examination courses, Writers Club and Faculty Membership details and application procedures
www.msoa.org.uk
### Contact information

**Chief Executive and Finance Director**  
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>Role</th>
<th>Name</th>
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</thead>
<tbody>
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#### Education and Research Directorate

<table>
<thead>
<tr>
<th>Role</th>
<th>Name</th>
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#### Professional Standards Directorate

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#### Training and Examinations Directorate

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The Royal College of Anaesthetists  
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