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ANAESTHESIA 2019

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A newsletter for anaesthetists in Wales

March 2019

Dr Abrie Theron

Welcome to the first College e-Newsletter for Wales in 2019! Hope you have all had a good festive or half term break and that 2019 has treated you well thus far.

The Task and Finish group looking into critical care capacity is progressing well and on the 22 February 2019 a stakeholder meeting was held with all work streams presenting their recommendations. One of the recommendations of the Transfers work stream will require anaesthetists. I have therefore asked the lead, Sue O'Keeffe, to write a short summary of their proposals. Anybody interested in this opportunity can email Sue directly.

Recommendations from the PACU, Outreach and Long-Term Ventilation will also be of interest to anaesthetists and intensivists and I am hoping to provide you with the final PACU recommendations and report in the next issue.

On 24 January I attended a meeting on Freedom to Speak Up, organised by BMA Wales, on behalf of the Academy. We have previously raised this matter with the Minister for Health and Social Care, CMO and Health Inspectorate Wales (HIW). Henrietta Hughes, the National Guardian for England was invited to talk and this was followed by a discussion on how to move this forward. Stakeholders from HIW, Health Education Improvement Wales (HEIW), the NHS Wales and Welsh Government were present and I am optimistic that this issue may move forward in Wales in 2019.

In December the Academy of Medical Royal Colleges Wales (AMRCW) met for the first time as a subcommittee of the UK Academy of Medical Royal Colleges (AoMRC). This was well attended and I am hoping that this is the start of renewed collaborative working amongst colleges in Wales.

This collaboration was started with a joint open letter to Andrew Goodall (NHS Wales Chief Executive), initiated by the Royal College of Physicians, asking for the NHS in Wales to look favourably on requests for professional leave from everybody working in the NHS, but in particular trainees.

During the joint College and the Association of Anaesthetists' Dinner in November I was sitting at the table which was discussing how to improve supervision. The different understanding of terminology used in this area was highlighted. We may need to define the roles of mentors, educational and clinical supervisor's better, as well as clarify what is meant by direct and indirect supervision and local/distant indirect supervision.

In a follow-up discussion with the RA(A) and Interim Head of School – Sarah Harries, I was pleased to learn that the Welsh School of Anaesthesia is already looking into some of the issues around Educational Supervision. Libby Duff from Aneurin Bevan has kindly provided us with an update on this work.

Professor Push Mangat, an Intensivist and Anaesthetist from Swansea, was appointed as the Medical Director of Health Education Improvement Wales (HEIW) at the end of last year. I am pleased to say that we have secured a meeting with him and the college for April where we will be discussing how we can work together to address the workforce needs facing anaesthesia and intensive care in Wales.

The Welsh government has opened a consultation: 'Healthy Weight: Healthy Wales' consulting on four main themes: Leadership and enabling change, healthy environments, healthy settings and healthy people. More information and how to respond can be found here.

Other contributions in the issue include a piece on where we are with the care we provide to patients with fractured neck or femurs and how we can improve this, a pain update, obstacles in setting up PQIP, the TALK project and Making Choices Togethers' Shared Decision-Making events in Wales which will be taking place later this year.

Can I also remind you of a few other dates below:

Society of Anaesthetists of Wales (SAW) www.anaesthetistswales.ac.uk	**Spring Meeting**, 8 March 2019 – Brecon, **Autumn Meeting** (Joint SAW/SWOAF) 17-18 October 2019 – Vale Resort Hotel
South Wales Obstetric Anaesthesia Forum (SWOAF)	**Spring Meeting** 10 May 2019 (full day) – Bridgend
Welsh Intensive Care Society (WICS) http://welshintensivecaresociety.org/	**Summer Scientific Meeting** 20-21 June 2019 – Llandudno, North Wales
South Wales' network of Acute Pain teams (Snap)	**Annual Scientific Meeting** 23 May 2019 – Cardiff
Welsh Perioperative Medicine Society (W-POMS)	**Annual Meeting** 7 June 2019 – Cardiff

Hope you enjoy reading through this issue.

Dr Abrie Theron,
Chair, RCoA Welsh Board

Recommendation for transfer model for Wales

Each year there are around 450 critical care transfers. This has decreased slightly since the establishment of the Emergency Medical and Retrieval Service (EMRTS), most likely because some patients are going direct to the correct destination in the first instance. Most critical care secondary transfers are undertaken by the Health Boards, some are carried out by EMRTS but the numbers are low, around 10% of all critical care transfers in 2018. Health Boards find it increasingly difficult to release staff, particularly appropriately trained medical staff, to undertake transfers.

Where possible EMRTS will undertake transfers if the patient fulfils certain criteria (see option 3). There is also a fourth (Welsh Air Ambulance Charity) aircraft primarily for children, but also available for critical care transfers i.e. not pre-hospital care. However, whilst EMRTS provide a Helicopter Transfer Practitioner escort, the sending hospital/HB is still required to send a medical escort. EMRTS are currently funded 8:00am – 8:00pm however there is a business case pending for EMRTS to provide 24/7 cover.

The current transfer model is less than ideal with frequent delays (usually due to for example, Welsh Ambulance Service Trust (WAST) and appropriate medical staff availability) and, not infrequently there are non-adherence to the Guidelines[1] (15.2% of returned forms that have the grade of staff documented show an inappropriate grade of staff, and therefore level of training, undertaking the transfer). Service reconfigurations, hospital designations and changes are likely to result in additional critical care transfers. The transfer model for Wales requires enhancing to ensure that patients are transferred as timely and safely as possible.

The Welsh Government's Task and Finish Group (T&FG) therefore requested the Transfers Workstream to:

- consider options for the development of a model of transfers for patients who are critically ill
- provide advice to the workforce work stream on any potential staff implications or training requirements.

Option one

Do nothing, status quo: Health Board staff, usually an anaesthetist and nurse or ODP, undertake transfer. This model of transfers has been in place for many years. In the main it works reasonably well but at times of pressure there are inherent delays, as in the introduction. This option is favourable in terms of costs but needs to be assessed in terms of current/identified difficulties with WAST asset availability and HB staff depletion.

Option two

Dedicated Regional Transfer Teams for non-urgent transfers in hours. The model proposes dedicated transfer teams in two regions (North and South). Such transfers could be transfers for capacity reasons or repatriations. These transfers do not form part of the core work of EMRTS and, as such, is the primary area that needs addressing to mitigate many of the issues cited above.

The key risk here is medical staff recruitment. It needs to be explored whether:

- anaesthetic consultants in Wales are prepared to re-job plan to take on this work
- the anaesthesia STC is in a position to allocate trainees to staff the model
- the creation of fellowships for NCCGs can be functionally operationalised.

If the answer to the above is not favourable, then the only likely way to staff the option would involve locum/WLI remuneration. This could be actioned as an interim while fellowships are created, and while the deanery/STC reorganise their training programme.

Option three

EMRTS undertake all critical care secondary transfers regardless of criteria. EMRTS currently undertake secondary transfers of the critically ill or injured which are time critical and require specialist intervention, or patients who are at high risk of deterioration. This model therefore proposes that EMRTS carry out all transfers including those for capacity reasons or repatriations.

The benefits of having a dedicated transfer service will be:

- no reliance on frontline WAST assets (therefore minimal delays)
- no depletion of hospital/HB frontline staff; workforce prudency
- improving flow for all hospitals but especially the tertiary centres
- compliance with Designed for Life: Welsh Guidelines for the transfer of the critically ill adult.

The use of EMRTS for non-urgent work is superficially attractive. However, the plan would have serious and disproportionate effects on EMRTS core business, and may precipitate an unacceptable situation with risk of reputational harm for both the Air Ambulance Charity and NHS Wales.

Recommendation:

Option two is the preferred option of the transfers workstream, however it does need to be assessed by the T&FG as to whether it is value for money. It is likely to cost around £1m to set up and then £500k p.a. Medical staffing is likely to be very difficult as most doctors are already fully job-planned with little scope for additional duties.

Regardless of option it is recommended that no capacity or non-urgent transfers will be undertaken out of hours (8:00pm – 8:00am).

Reference

1 Designed for Life: Welsh guidelines for the transfer of the critically ill adult

Dr Sue O'Keeffe
Critical Care & Trauma Network Manager, Wales

How do we improve the quality of our educational supervisor reports?

In September 2018, the Wales Deanery (now HEIW) held a seminar for Training Programme Directors (TPD) and College Tutors (CT) from primary and secondary care. The aims of the seminar were to provide updates on upcoming developments and to provide an in-depth summary of the review and appeal process of annual review of competence progression (ARCP) outcomes.

Anaesthesia was well represented and there was a vast amount of useful information presented, supplemented with trainer's own experiences of challenges. The important roles and responsibilities of Educational Supervisors (ES), TPD, Annual Review of Competence Progression and Appeal Panel Chairs were highlighted.

Case studies provided an excellent platform for discussion on effective, fit for purpose ES report writing. We were able to share ideas and thoughts on current practice across specialities, with the aim of implementing change. As a speciality, we were

encouraged to consider the consistency of ES structured reports (ESSR) and focus our minds on how we could implement changes to improve quality assurance across Wales in producing these reports.

The ESSR is the form that summarises a trainee's portfolio for the training year prior to ARCP. The trainee creates the form on their College e-portfolio or Lifelong Learning Platform (LLP) and then populates it with all their training evidence. Once completed, the form is sent to the ES to review, edit and comment on their training progression before sending it to the CT to add final comments. The ES plays a crucial role in ensuring a trainee achieves the many requirements to progress through the training year successfully. This includes examinations, work-based place assessments (WBA), unit of training (UoT) sign offs, multi-source feedback (MSF) and feedback forms, an up-to-date logbook and a reflective diary.

They are also pivotal in encouraging trainees to engage in the College Annex G activities, which consist of quality improvement, education and research. The Welsh School of Anaesthesia has a fully informative website www.welshschool.co.uk for trainees and trainers which provides clear guidance on preparation for ARCP in the form of a checklist. This checklist ideally should be the focus for both the trainee and trainer in successfully completing a comprehensive ESSR.

Within the Welsh School of Anaesthesia, we have recently asked ourselves:

- What makes a good quality ESSR? How can we gain more consistency in ES reports produced across Wales?
- How can we support our ES to produce high quality reports?

The quality of an ESSR is often obvious to those that review them repeatedly at ARCPs. However, most ES write a maximum of four per year. It is therefore not surprising that this is a relatively new challenge at the end of each training year. Of utmost importance for an ESSR being fit for purpose and high quality, is ensuring that all the information required by the ARCP panel is present and covers progress against all required competencies.

A detailed review of the Welsh School checklist is paramount in achieving this:

- clear evidence-based judgements referenced to the e-portfolio with precise descriptions of progress (strengths and weaknesses)
- clear educational objectives and targets with advice and support offered to trainee comprehensively documented
- a summary of attitudes, relationships and engagement with the training programme made clear, referenced to all feedback supplied. This should also include communication skills, critical incident issues and any concerns relating to health and probity issues.

In January 2019, the Welsh School commenced a quality review of Educational Supervisor reports. The aim of this on-going review programme is to highlight what ARCP panels feel result in high quality report writing. There are aspects of this where we already have insight but there may be other individual practices which are less obvious, but highly effective.

Panel chairs used a focussed pilot audit tool for all ESSRs reviewed at ARCP in January 2019. A review of the scope and standard of these reports was documented with the aim of fine-tuning the form for on-going use. Following ARCPs in the summer of 2019, the School hopes to be in a position to use this tool as a standard constructive feedback tool of an ESSR to be returned to ESs and College Tutors.

The School is keen to fully explore the variety of approaches to report writing and reflect on this to improve support and hence practice across Wales. The reports reviewed at ARCP are often varied, and it may be that with more standardised structured guidance, we could improve consistency and support. The quality review is in its early stages at present, but we hope to have concrete ideas by the summer of 2019 on which we could base focussed training and the introduction of a quality report template.

Dr Elizabeth Duff
Consultant Anaesthetist, Aneurin Bevan Health Board
Deputy Trainee Programme Director, Welsh School of Anaesthesia

Association of Anaesthetists Awards

It is pleasing to announce that two Welsh consultants: Professor Rachel Collis and Dr Ian Appadurai, were honoured by the Association of Anaesthetists at its Winter Scientific Meeting in January.

Professor Rachel Collis was awarded the Association Anniversary Medal for her huge contributions to academic obstetric anaesthesia in Wales and for outstanding service to the Association. Her ground-breaking research work in obstetric haemostasis is more than excellent science: through leading the Quality Improvement work of the ObsCymru initiative, she is implementing the fruits of good research throughout Wales, and further afield. This work is translating research evidence into clinical practice and helping to save mothers' lives during childbirth. Rachel has also been an influential member of the Association Board and Council from 2012-18, brilliantly chairing the International Relations Committee and the Draw-over Anaesthesia Checklist working party. In the last two years, Rachel has served as Association Vice President, bringing her vast experience, skills and good sense to the work of the Association.

You can read Rachel's full citation here.

The Association's Evelyn Baker medal was instigated by Dr Margaret Branthwaite in 1998 and is dedicated to the memory of one of her former patients at the Royal Brompton Hospital. The award is made for outstanding clinical competence, recognising the 'unsung heroes' of clinical anaesthesia and related practice. Such individuals are deemed to have great technical proficiency, consistently reliable clinical judgement, wisdom, and skill in communicating with patients, relatives and colleagues. The ability to train and enthuse trainees and colleagues is seen as an integral part of communication skills. Nominees are often described as the unspoken backbone of their department and the 'go to' person for clinical or other advice. Dr Ian Appadurai was nominated for the Evelyn Baker Award by members of his own department who describe Ian as the 'original' perioperative physician. He always goes the extra mile by thoroughly assessing and reassuring his patients before surgery, and it was Ian who introduced and championed cardio-pulmonary exercise testing in his department. By putting his patients and colleagues ahead of any personal advancement, Ian is an inspiration and role model to his colleagues and a thoroughly deserved recipient of this prestigious award.

You can read Ian's full citation here

Hip fractures in Wales, a lot is happening

The recent National Hip Fracture Database (NHFD) report made for difficult reading in Wales as it showed Welsh overall mortality (adjusted) is around 8.6 per cent, compared with 6.9 per cent for the UK as a whole[1]. Time to theatre target, within 36 hours, was met for only 59 per cent of our patients. England have a Best Practice bundle (a set of certain NHFD factors) and comply with this in over 90 per cent of cases, but Wales achieves the same for only 6.6 per cent of patients.

Despite this report[2], a summation of 2017's data, a lot is already happening in Wales to tackle the care of frailty fracture patients. Welsh government and the Deputy Chief Medical Officer for Wales, together with the Welsh Delivery Unit, are introducing monthly reviews against a set of seven key performance indicators, which represent all aspects of a patient's care from admission to discharge. Each hospital and Health Board will be reviewed and their progress assessed against these and help will be given to standardise care in Wales. The aim is to drive up the level of care by helping every Health Board become further attuned to managing this frail vulnerable population. There are already pockets of fantastic care and we aim to share these successes with everyone.

These plans are supported by the Welsh frailty Fracture Network (WFFN) who are a multidisciplinary action group for Frailty, including hip fractures. WFFN began as a group of interested anaesthetists from every hospital in Wales and they have standardised the anaesthetic for all hip fracture patients across Wales with their pragmatic guideline (it guides how best to proceed for either general anaesthetic or spinal for example). The guideline is available in all trauma theatres across Wales and a recent audit showed, within one year of adoption, it was in use in over 85 per cent of operations. This anaesthetic guideline is set to become the basis of the new the Association of Anaesthetists' best practice guideline. WFFN has now expanded to involve representatives of all specialties involved in Frailty Fracture care – such as nurses, physiotherapists, dieticians, surgeons and orthogeriatricians and are producing more practical MDT policies and initiatives.

Surprising to many anaesthetists is the level of impact we can have on frailty fracture outcomes. We know that general anaesthesia, especially over-anaesthetising patients, as well as the use of long acting benzodiazepines, opiates and codeine, are associated with post-operation delirium and can worsen dementia[3,4]. Delaying an operation even for half a day can increase perioperative complications and prolong rehabilitation, and the prolonged pre-op starving of patients, as we continually delay their operation, worsens malnutrition and can further increase complications. As well as this there are specific NHFD variables related to anaesthesia that can be improve upon[5]:

- reduce time to theatre by limiting medical delays with prompt assessments
- aid mobilising day one by addressing a triad of immediate post op factors – analgesia, low haemoglobin and hypotension
- reducing intra-op opioids use by using fascia iliaca compartment nerve blocks (FICB) for all cases. GA patients require lower MACs with a FICB. FICB use being a recorded variable.

There is a lot to do in Wales but also a lot going on here. Every Anaesthetist can make a difference and in so doing help improve the standard of care these frail patients deserve. Following the WFFN Anaesthetic guidelines is a start. If you would like more information, or get involved, please email Dom.Hurford@Wales.nhs.uk.

Dr Dom Hurford
Consultant Anaesthetist
Chairman of the Welsh Frailty Fracture Network

References:

1 www.nhfd.co.uk
2 National Hip Fracture Database annual report 2018. London: RCP, 2018.
3 Perioperative Care of the Elderly 2014 AAGBI Safety Guideline Jan 2014.
4 Strøm C, Rasmussen LS, Sieber FE. Should general anaesthesia be avoided in the elderly? Anaesthesia 2014; 69(Suppl.1); 35–44.
5 Guidelines for the management of Hip Fractures Association of Anaesthetists Great Britain and Ireland 2011.

Pain Medicine in Wales

Pain medicine in Wales is an exciting, continually evolving specialty that allows anaesthetists to work at the core of multidisciplinary pain services, with the goal of making a positive difference to patient's lives. Pain remains high on the agenda in Welsh government and there has been recent consultation on a document Living with Persistent Pain in Wales. Amongst its aims, it hopes to provide a focus for Welsh health boards and other authorities to improve the range and quality of services for people living with persistent pain. I hope this will help us continue to attract high calibre anaesthetists and multidisciplinary health care professionals to work in pain medicine in Wales.

The Faculty of Pain Medicine (FPM) is responsible for the training, assessment, practice and continuing professional development of specialist medical practitioners in the management of pain in the UK. Whilst the FFPMRCA examination is now a requirement for fellowship of the FPM, some important and beneficial new routes of membership have recently been introduced.

The route of 'Affiliate Fellowship' has been created for acute/inpatient pain medicine doctors and consultants in pain medicine. There is a strong view from within the Faculty that it should be home for doctors active in all types of pain medicine and the FPM hopes to evolve to have much stronger connections to the world of acute/inpatient pain medicine.

This route is also open to pain medicine consultants without the FFPMRCA examination who are not eligible for fellowship by any other route. This may be of interest to anaesthetists working in Wales who wish to develop opportunities linked to the FPM, such as training and I would urge anyone to consider applying if they think it may be relevant to them.

The other new routes include 'Affiliate' – a route for all healthcare professionals and the potential route of 'Foundation Fellowship' - for non-anaesthetic pain medicine consultants. Please keep checking the website for updates on these developments.

In recent years, there has been an expansion in number of anaesthetic trainees embarking on and successfully completing advanced training in pain medicine in Wales. We have a great track record of trainees securing their desired consultant post. With attractive service development proposals and some remaining vacant consultant posts, the employment opportunities in Wales look rosy.

Dr Sonia Pierce
Regional Adviser in Pain Medicine (Wales)
Betsi Cadwaladr University Health Board

Setting up PQIP in Cardiff

Millions of patients undergo surgery in the NHS every year. We currently have limited data on complications, long term morbidity and how it affects patients' quality of life and life expectancy. This has paved the way for PQIP.

The Perioperative Quality Improvement Project (PQIP) aims to improve the way we look after our major elective patients throughout the perioperative phase. The annual report from 2017/2018 highlighted five main areas for improvement against which every hospital involved will be benchmarked in quarterly reports.

After hearing the related presentations at Welsh Perioperative Medicine Society (W-POMS) last year, we thought this would be a great opportunity to get involved. At University Hospital of Wales (UHW) we are close to getting started but I am going to highlight some challenges we have faced along the way.

Initially we contacted the study centre to register our interest. The approval and capacity and capability assessment then had to be sought from the local R&D department. This should be straightforward and the study centre suggests it takes a month or two. In our experience it has taken longer than that.

There is no initial funding for PQIP, therefore if a dedicated research team is not already available, this will impact on whether the directorate has capacity to fulfil the projects' needs. This was a challenge for us, but our Research & Development department has a research workforce team, which consist of clinical and non- clinical staff who are available to support research projects. They are experienced in getting projects off the ground and picking up snags in the logistics of how a project will run. Having contacted them we now have a research nurse and ODP who are heavily involved in PQIP.

Once the capacity and capability assessment was close to completion we arranged our teleconference with the study centre. This was extremely useful and provided the opportunity to ask questions about the data collection forms, consent and logistics of the project, although the website is really comprehensive.

I also sought advice from other centres that have started recruiting; it is great to get ideas from others who may have experienced similar difficulties. It is crucial to get as much clinical support and help as possible.

There are many QI opportunities with PQIP and trainee involvement can be rewarding. However, as trainees rotate regularly, it is also vital to ensure there is support from the department as a whole.

Engagement from the surgical specialties is also very important. Some could have reservations about perioperative information being collected and 'benchmarked'. We have decided to start with two surgical specialties in the initial phase and arranged to speak at anaesthetic and surgical audit to explain the project and invite questions. The response was very positive. (The PQIP website has podcasts and videos that can help prepare you for any awkward questions!)

Once we start recruiting I am sure we will face more challenges. However, I am sure it will be a rewarding project and that the real-time and quarterly reports we will produce quality improvement. I am very confident that PQIP will improve the way we look after our major elective surgical patients.

Dr Sara Churchill
Locum Consultant Anaesthetist
Cardiff & Vale Health Board

Talk: a tool for structured clinical briefing

In 2014 three anaesthetists (C. Diaz-Navarro, S. Pierce and myself Andrew Hadfield) with an interest in simulation and debriefing, started developing a tool to facilitate team self-debriefing in the clinical environment. We felt that there could be many benefits to these structured learning conversations, including improvements in patient safety, team culture and staff wellbeing.

We used our knowledge of debriefing as well as experience working in complex, dynamic environments to design a tool that was short and easy to understand, but powerful enough to deliver real improvements in patient safety and team performance. At all times our aim was to foster a culture of inclusivity and empowerment, enabling anyone to speak up when they had ideas to improve patient care. The tool is as follows:

T	**Tell us your perspective:** How do all team members see the situation? **Target:** What shall we discuss to improve patient care?
A	**Analysis:** Explore specific points of patient care as appropriate 1. What helped or hindered... - communication/decision making/situational awareness/efficiency? 2. How can we repeat successful performance or improve?
L	**Learning points:** What can the team learn from the experience?
K	**Key actions:** What can we do to improve and maintain patient safety? Who will do it?

We presented this concept to the international medical education community. It was very well received and the experience led to a number of collaborations with like-minded institutions. In 2016 these were formalised into a three-year multinational EU Horizon 2020 project between Cardiff and Vale UHB, Barcelona University, and the University Hospitals of Barcelona and Stavanger, with significant grant funding awarded. Each institution committed to implementing the project in various clinical areas, as well as sending and receiving a number of Marie-Curie fellows to undertake month-long secondments aimed at learning, developing and implementing patient safety initiatives related to the project in their areas of interest.

In January 2017 we introduced the tool to the main and day-case theatres at UHW, collecting data on its use pre-and post-implementation, and then at three and six months. We found that consideration and practice of debriefing after each theatre list increased significantly post-implementation, and this effect persisted at three and six months. In addition we became aware of a number of instances where use of the tool had prompted a conversation leading to changes being made with a direct benefit to patient safety.

These initial results are very encouraging. We have also been amazed by the interest shown in the tool, both locally and internationally, with many new collaborations in the pipeline.

This year at UHW we are receiving fellows from Norway and Spain to assist with implementation and research in other areas of Cardiff and Vale UHB as the project rolls out further. These areas include Neonatology, Radiology, Resuscitation and the Emergency Department. Exciting times!

Dr Andrew Hadfield
Consultant Anaesthetist
TALK Co-ordinator for Cardiff & Vale UHB
www.talkdebrief.org

Training the trainers to spread shared decision making

GWNEUD DEWISIADAU GYDA'N GILYDD MAKING CHOICES TOGETHER
Partneriaeth Dewis Doeth Cymru / Choosing Wisely Wales Partnership

Shared Decision Making is the key to open, respectful conversations between patients and clinicians, that identify 'what is most important' to the individual patient, and chooses the most appropriate management option for that patient from the range of relevant options. Shared decision making is an essential part of achieving the Prudent Healthcare Agenda in Wales, but implementing it into practice is challenging.

Two days of training (Spring 2019) will be provided by Cardiff University's international experts in shared decision making and healthcare communication. The trainers will draw upon their team's extensive experience and learning from working with patients, clinical teams and healthcare organisations to implement shared decision making, to train others to adopt it into practice.

Trainers:
Professor Adrian Edwards (Professor in General Practice, Cardiff University) – expertise in SDM training and implementation, Quality Improvement methods

Dr Natalie Joseph-Williams (Lecturer in Improving Patient Care, Cardiff University) – expertise in SDM training and implementation, measurement, patient engagement

Professor Paul Kinnersley (Professor (retired) School of Medicine, Cardiff University) – expertise in Train the Trainer, healthcare communication & SDM training.

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DAY ONE (10 April – North Wales or 22 May, Cardiff)	DAY TWO (optional: 12 June, Mid-Wales)
Introduction to Shared Decision Making: Principles, skills and evidence base	**Training the Trainers: Delivering training and planning implementation**
■ Introduction to shared decision making ■ The role of shared decision making in the Prudent Healthcare Agenda in Wales ■ Shared Decision Making Skills Workshop – key skills for using this approach in routine consultations ■ Barriers and facilitators to implementing shared decision making in routine clinical settings – practical tips on how to overcome the key challenges	■ Reflection and review of your experiences to date ■ Training the Trainer – we will provide further training on how to deliver this training to your colleagues (including the resources) ■ Planning for implementation - we will use the learning from a national shared decision making implementation programme (MAGIC) to help you plan for implementation in your own organisations

For more information please contact MakingChoicesTogether@wales.nhs.uk

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