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APRIL 2023

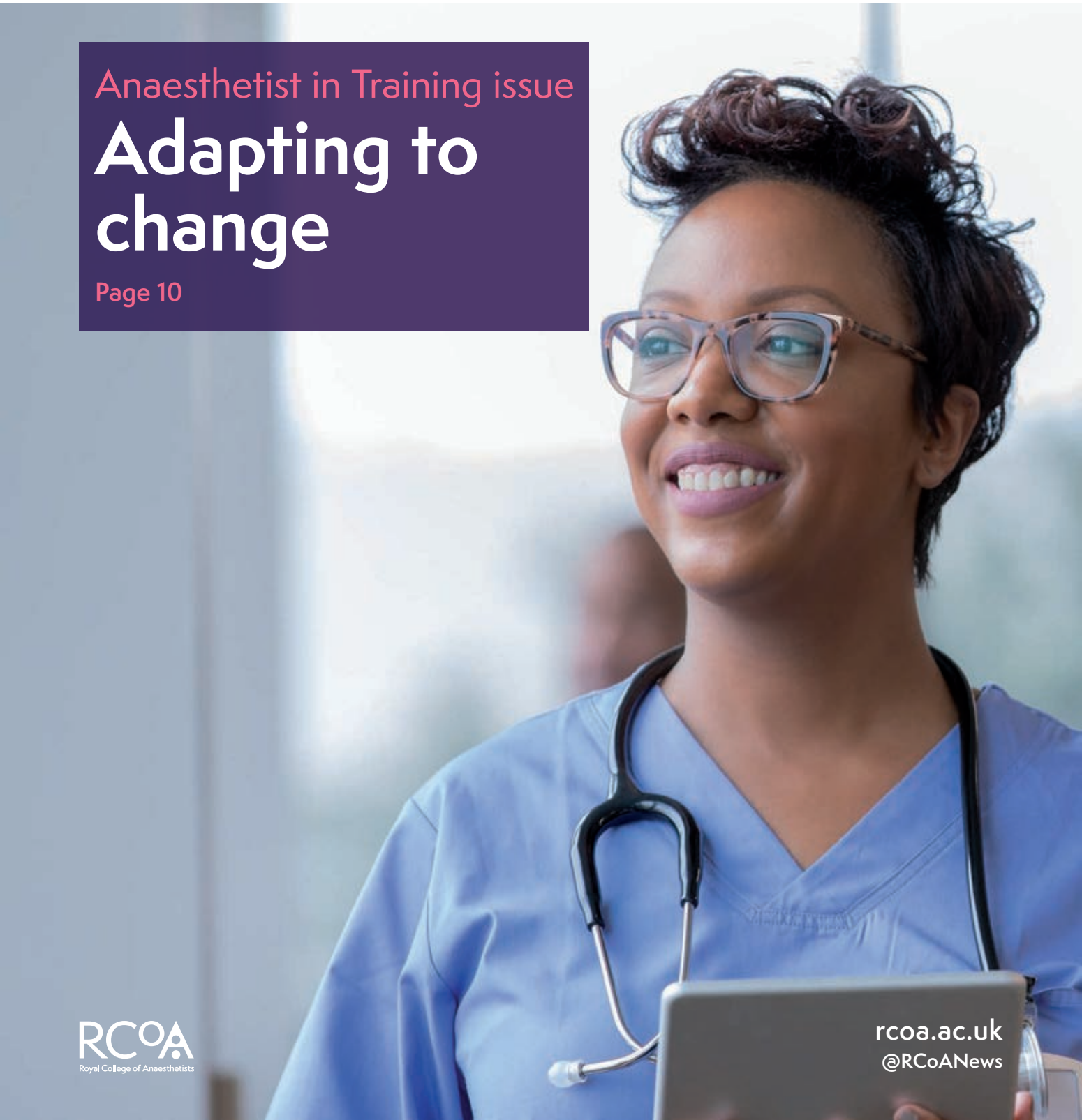
Bulletin

The magazine for members of the Royal College of Anaesthetists

Anaesthetist in Training issue

Adapting to change

Page 10



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MAY

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Edinburgh

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RCoA, London
FULLY BOOKED

Anaesthesia 2023
16–18 May 2023
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Birmingham and online

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23 May 2023
Online

AaE: anaesthetists' non technical skills (ANTS)
26 May 2023
Online

Senior Fellows and Members Club
26 May 2023
Bristol

JUNE

RCoA and BJA webinar - noninvasive neuromodulation for pain
8 June 2023
Online
FREE EVENT

FPM De-escalation of Opioids Study Day
9 June 2023
RCoA, London

FICM ACCP National Conference 2023
12 June 2023
RCoA, London

AaE: An Introduction
13 June 2023
Online
FULLY BOOKED

Anaesthetic updates
14–15 June 2023
RCoA, London

Returning to work in anaesthesia
21 June 2023
Online

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

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From the editor

Dr Ramai Santhirapala

Welcome to the April 2023 anaesthetist in training (AiT) edition of the *Bulletin*. As I write this, NHS doctors in training are imminently embarking on industrial action following an unequivocal ballot; unprecedented since 2016. Whatever your opinion on industrial action, the common thread is that these are intense times for those of us within the NHS. It is often these times, however uncertain and unsettling, that further solidarity for the betterment of care for patients and each other. The conversations I have had with anaesthetists across the UK bring forth this sentiment; we are in this together.

'Adapting to change' is the theme for this edition of the *Bulletin*. No better place to start than to introduce our new anaesthetist in training members of the *Bulletin's* editorial board, Dr Lauren Elliott and Dr Nipun Agarwal, who have been an absolute joy to work with for this issue. In their Guest Editorial (page 10), they relay the challenges from the training pathway, career progression, and wellbeing faced by those training in anaesthesia within the UK. On the subject of introductions, it is a delight to warmly welcome our new members of Council (page 30) in this issue, including three positions representing anaesthetists in training. Furthermore, this issue contains details of other roles in the College that focus on education and training (page 32).

It is heartening to read that, even during these turbulent times, anaesthetists at all stages of their careers turn problems into solutions that strengthen national and international best practice. Dr Natalie Constable and colleagues describe the working arrangements for an established response team for one of the most critical emergencies faced by our specialty – the difficult airway (page 14). In these time-critical scenarios, human factors, and a systematic approach are essential to team working. This is further iterated in an article by Dr David Luther and colleagues, translating national resources into local practice – unsurprisingly implementing a flattened hierarchy improves patient safety (page 16). The theme of multidisciplinary working in translational practice is elegantly relayed in updates from the Perioperative Quality Improvement Programme, led by Professor Ramani Moonesinghe (page 20), and the National Emergency Laparotomy Audit, led by Dr David Saunders (page 48). Imperative to such initiatives is the active incorporation of patient voices (page 44).

I am signing off on this issue on a personal note as I look forward to celebrating New Year again. 'How is that?' you might say. As someone who remains rooted in South Asian (Sri Lankan Tamil in my case) culture, I will be honouring Tamil New Year – which occurs annually on 14 April. It is celebrated internationally and represents a renewed opportunity for hope and fortitude. The synergy as we enter the season of spring here in the UK feels pertinent. Times are no doubt challenging for our specialties and for the healthcare workforce at large as we continue to strive towards excellence. To inspire thought, I will leave you with a quote from none other than Albert Einstein: 'In the midst of every crisis lies great opportunity'.

The President's View

Supporting anaesthetists in training

Dr Fiona Donald
President
president@rcoa.ac.uk

Being an anaesthetist in training has always had its challenges, alongside the many opportunities and benefits offered by our specialty. However, I think that those of you currently in training are facing a particularly tough time. And without wanting to be too downbeat, I think it's important for the College to recognise that, to reiterate our commitment to supporting you and to update you on what we are doing to try and improve your working lives.

There could be no stronger reminder of these challenges than the fact that, as I write this, junior doctors are about to begin the first day of a 72-hour strike. Although unsurprising, the overwhelming support for industrial action among junior doctors is further evidence of just how frustrated and undervalued they are feeling. Our job is to ensure the voices of our members are heard and understood. We *do* value you, and while we do not have a role in negotiations about terms and conditions of employment, we have made it clear that we believe the exclusion of doctors in training and SAS doctors on the reformed contract from the government's pay deal is likely to exacerbate the NHS staffing crisis. We will continue to make that point to government as we advocate action to address workforce shortages and pressures.

Seeking support

On an individual level, I also understand that this is a difficult and stressful time. I often talk about 'our members' collectively when referencing the pressures you are under and the action the College is taking to advocate the interests of all within the specialty. But I don't lose sight of the fact that our members are thousands of individual people, each of whom has a set of circumstances – at work and at home – that are unique to them. While there are challenges we all share, we can also be differently affected on a personal level.

There is support available to anyone who needs it. The BMA has a free and confidential 24/7 counselling and peer-support service open to all doctors and medical students, regardless of BMA membership, as well as to their partners and dependents. The NHS has a confidential text support service and a self-check tool to access available support. You can find signposting to these and to other sources of support in the industrial action advice and frequently asked questions on our website.

I would also recommend the article by Dr James Wicker and Dr Elodia Dalmonte on tackling trainee-burnout, which provides an interesting case-study of how their practical initiative of setting up a Coffee Club has helped provide a space for peer support (page 12).

We will continue to campaign on your behalf for the further expansion of training places.

Advocacy for more training places

In addition to pay, workforce shortages remains a key issue facing our specialty and the NHS more widely. The College does not set the number of training places, but we consistently make the case for more to statutory education bodies, including Health Education England (HEE), and to government. I am pleased that we have had some success, with HEE providing 70 additional ST4 posts in February and agreeing a further 70 for 2023/4 in England. There are 15 extra ST4 posts approved for Scotland and 6 for Wales.

This will not fully meet the need, and we will continue to campaign on your behalf for the further expansion of training places. In the last few months I have raised this issue at meetings with Will Quince, Minister of State at the Department for Health and Social Care, and Steve Brine, Chair of the Health and Social Care Select Committee.

At these meetings, I also reiterated the need for government action to reform the current pension–tax system, which is forcing many experienced doctors to reduce their hours or to retire early. In the run up to the Budget, I wrote to the Chancellor, Jeremy Hunt, to push for more action on both pension tax and training places (at the time of writing there is some speculation that we may see positive news on the former). And together with colleagues on our Welsh Board, we have advocated similarly in response to the Welsh government's National Workforce Implementation Plan.

Underpinning this campaign is the evidence we provide through our *State of the Nation* report, which draws on data from our workforce surveys to detail the extent of the shortage of anaesthetists and what is needed to address it. We will shortly publish an update to the *State of the Nation* report, which will provide more contemporary data and further strengthen our case.

Developing our exams

We have recently published our programme of improvement for our exams, setting out proposed changes that we will make over the coming months and years. While our exams continue to be valid, reliable and approved by the GMC, we are committed to making improvements in line with contemporary best practice in medical education. These improvements are informed by two reviews – an internal review of the FRCA and an independent review of our assessment processes undertaken by Professor John McLachlan. We published both reviews earlier this year, and there is a great deal of alignment in their recommendations.

The independent review captures the experiences and views of our members, particularly those of anaesthetists in training and examiners. Many candidates told us about the impact of exams not only on their careers, but also on their personal lives. I am very grateful to everyone who contributed so openly and honestly to the review.

Given the significance of exams to those taking them, I want to emphasise that we will – as always – ensure that we give candidates at least 12 months' notice of any significant changes in order to facilitate good preparation and support. There is no need for candidates to change the way they prepare for the current sets of exams until formally notified of any changes.

One of the most important changes we are making is to give anaesthetists in training a greater role in our assessment processes. This includes representation on our new Examinations Development and Assurance Group, which will lead the development, quality and alignment of all exams delivered by the College. Anaesthetists in training will also play a more central role in supporting communications with candidates. Dr Lauren Elliott and Dr Nipun Agarwal, our new anaesthetist-in-training members of the *Bulletin's* editorial board, provide some initial reflections on exams, as well as wider teaching and assessment issues, in their guest editorial (page 10).

Another key part of our programme of improvement will be to review the purpose of our assessments in accordance with the changes made in the curriculum and the changing nature of clinical practice in our specialties. We will consult with members and stakeholders as part of that process.

We will also undertake new research to inform our assessment design process. We are committed to investigating the impact of gender, ethnicity and educational background on exam performance. This work sits alongside our differential-attainment action plan, which sets out what we are doing to improve outcomes and

address the inequalities that – as a recent GMC report shows – are evident across postgraduate medical education. We also aim to undertake validity research to compare exam performance with performance in the workplace as estimated by trainers and supervisors.

Representing you at the UK Covid-19 Inquiry

I am pleased that the College, the Faculty of Intensive Care Medicine and the Association of Anaesthetists have been successful in our joint application to be a Core Participant in Module 3 of the UK Covid-19 Inquiry. Module 3 will examine the impact of the pandemic on healthcare systems, patients and healthcare workers.

We believe we are expertly placed to shape and inform that process, not least because, taken together, our members represent more than 24,000 doctors and healthcare workers who played a direct and significant role in the UK's response to the pandemic. In fulfilling this role, we will use the extensive data and testimony that you provided to us at the time.

Being a Core Participant means that we will have a formal role in the Inquiry, as defined by legislation, and have special rights in the process. These rights include receiving privileged access to documentation, suggesting lines of inquiry and being represented and making legal submissions. When we have more details of the way in which the Inquiry will work, we will let members know how they may be able to contribute further to our evidence-giving.

If you have any comments or questions about any of the issues discussed in this *President's View* or any other subject, I would like to hear from you.

Please contact me via:
presidentnews@rcoa.ac.uk

Bulletin

of the Royal College of Anaesthetists

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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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Jono Brüün
RCoA Chief Executive Officer
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CEO Update

Changes that are making a difference

The College is moving forward at pace as we work to implement improvements to our member services and benefits. On the staff team we are all too aware of the challenges you are facing at work, and our goal is to meet your professional needs and to support you in delivering safe and effective patient-centred care.

In her 'President's View', Dr Fiona Donald outlines our programme of development for exams, including how we will give anaesthetists in training a greater role in our assessment processes. This has been a major priority for us over the last 18 months as we have sought to investigate how we can make improvements across all aspects of our exams. To help us deliver these improvements we are increasing capacity within our exams team. This additional expertise will enable careful implementation of longer-term changes alongside the regular face-to-face and online delivery of our exams.

While exams will always be inherently high-stakes assessments, our aim is to ensure that each and every candidate has the best possible experience. Since August 2021, a total of 7,554 candidates have sat our exams, all of whom have been offered the opportunity to provide us with feedback. Our exams team review all candidate feedback, and it is also considered during moderation- and item-analysis meetings. I hope candidates will continue to provide us with these valuable insights.

Prioritising member services

Like many organisations, we are having to adapt in the face of financial challenges. The pandemic was a major disruption, primarily because of the enormous pressure it put on our members, but also because it increased the financial stress on the College. In addition, we are seeing steep increases in our running costs resulting from the current high level of inflation. In response, we have made changes to our business model and put in place a recovery plan, which is already having a positive impact.

We know that you are feeling the impact of the increased cost of living too, and we will always put our members first when it comes to making financial decisions. We are currently reviewing all College activities to identify where we can make further savings without reducing any of the services and benefits we provide to members. For example, we will retain our commitment to running our exams at cost. We do not make a surplus from examination fees – the amount we charge candidates reflects the significant amount of work and expense that goes into running exams, and nothing over and above that.

Innovation in events and educational content

We continue to run a full programme of training and development events. In shaping our events programme, we have responded to your feedback as to what constitutes the right mix of face-to-face, online, and hybrid delivery. We want to ensure that whatever your training and professional development needs, there are options accessible to you in terms of format, timing and content.

Since the start of the College's financial year in July 2022, we have run 63 events, which have been well attended and received positive feedback from members. We have an exciting few months ahead, not least our flagship annual conference *Anaesthesia 2023*, which will be held in Birmingham in May. You can attend in person or online for an action-packed three days of learning and networking opportunities.

If you haven't done so already, I can also recommend subscribing to our podcast, *Anaesthesia on Air*. The episodes are designed to reflect our members' diverse range of interests. Sometimes the conversations are a deep dive into a new development in clinical practice, for example a recent episode on embedding new safety standards for invasive procedures. Others bring an interesting perspective from anaesthesia to a wider audience, like our recent two-part episode with Dr Ian Roberts, Medical Rescue Coordinator for Formula 1 Motor Racing.

We have also revitalised our Education Programme Quality Working Group, comprising members who want to help us develop new educational content and events. If you have ideas for content or events you want us to produce, or suggestions about how we can improve, please email us at events@rcoa.ac.uk.

A modern approach to governance

In February we received Orders from the Privy Council approving amendments to the College's Charter and Ordinances as approved by members at our AGM. These changes will improve our efficiency, accountability and transparency. I am grateful for your engagement in this process, which enabled us to refine and strengthen our proposals.

The value of this collaborative approach between the College leadership, staff and membership is something we want to harness, and I hope that many of you will come to one of our *Let's Talk* events, which provide an open forum for us to listen and respond to members' views. The next *Let's Talk* online event is on 18 April, and you can register on our website at rcoa.ac.uk/events/lets-talk-3. We will host another in May at *Anaesthesia 2023* – I hope to see you at one soon.

More information

Anaesthesia 2023
rcoa.ac.uk/anaesthesia

Anaesthesia on Air
rcoa.ac.uk/podcasts

Let's Talk
rcoa.ac.uk/events/lets-talk-3

Guest Editorial

ADAPTING TO CHANGE

As your new elected anaesthetist in training (AiT) members of the *Bulletin's* editorial board, we would like to welcome you to the AiT edition of the *Bulletin*. We are very excited to be taking over from Dr Susie Thoms and Dr Soumen Sen, and would like to thank them for their excellent work with both the *Bulletin* and *The Gas* in recent years.

Looking at the current landscape, we wanted to touch on a few issues that we have recently been discussing within the College's Anaesthetists-in-Training Representative Group and its Anaesthetists-in-Training Committee.

Teaching and assessments

As most teaching and clinical assessments gradually return to face-to-face delivery, there are an increasing number of challenges being posed for all. There are clearly issues to be addressed regionally and nationally to ensure that trainees are able to make the most of their teaching time and to progress professionally in a timely manner. We are pleased that the College and other bodies are making efforts to understand the constraints and stressors faced by the current cohort so that practical solutions can be offered.

At the time of writing, a recent publication of the internal FRCA examination review is due to be followed by an external FRCA examination review. The recommendations so far highlight the fact that some components are clearly working well and also that there are aspects of both the Primary and Final exams where updates are required. We welcome the regular review process's reflection of the changing training environment, and its increasing recognition of the equality, diversity and inclusivity needs for exams and beyond.

Recruitment

We have many colleagues stuck in the training bottleneck and fighting for an ST4 post. Some are choosing to leave the NHS in search of the increased pay, the improved work–life balance, and the better climates that working abroad offers. Others are pursuing alternative routes via SAS or CESR pathways, and these are options that are becoming increasingly attractive to our junior colleagues, with their anxiety around career progression opportunities and lack of ST4 posts, compounded by the frequently changing recruitment process and criteria.

Behind the scenes, the College is trying to help. We are delighted that there is movement on the creation of more training posts, with an additional 70 posts being created for both February and August this year. The number is governed by Health Education England, and, while far from enough in terms of numbers, it is a step in the right direction. The other priority is making the selection process as fair as possible, including the use of multi-station interviews with four assessors to reduce bias. With the continued AiT input around recruitment, we are confident that things will improve.

Wellbeing

With the increased intensity of out-of-hours work, fatigue, tight rotas, constant requests for locum cover (with the common inability to say no!), juggling work and family life, strike action, exam and recruitment worries, not to mention the cost-of-living crisis, we don't have it easy at the moment; mental illness is significantly higher in doctors than in

Dr Lauren Elliott
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I am an ST7 anaesthetist in training in the North West and embarking on my final year of training. I am passionate about making our time in training the best it can be and am looking forward to working with the *Bulletin* and *The Gas* teams to deliver some interesting and relatable reading.

Dr Nipun Agarwal
RCoA Anaesthetist in Training Committee

I am an ST7 anaesthetist in training at the Stoke-on-Trent School of Anaesthesia. With the College, I would like to make the training experience smoother for AiTs wherever possible. It is a pleasure to read all the articles sent by colleagues across the country – from weird and wonderful, to heartbreak, to innovation and everything in between!

the general population. We are resilient, but we are at risk.

Here are some recent activities from the North West Deanery that help to address wellbeing and mental illness.

FEST North West – an event full of fun, activities and socialising that all trainees were encouraged to attend (funding and study-leave provided!). Following an overwhelmingly positive response to this day, we are looking forward to making it an annual event in the North West. One of the most important outcomes was that trainees felt more valued – a highly recognised protective factor in mental health.

Breaking Barriers – a regional Specialty Training Committee day, including presentations by three anaesthetists discussing their personal experiences of mental illness. 'Emotional', 'powerful' and 'brave', are just some of the words that came to mind, and the audience was captivated. Hearing these individuals convey the realisation, progress and improvement of their mental illnesses was so powerful, but, most importantly, immensely helpful in overcoming the barriers to speaking up or seeking help.

Your local AiT representatives are here to help with any issues and are your links to AiT groups at the College, where we will continue to do our best to advocate for you, so please get in touch if needed by emailing trainee@rcoa.ac.uk

We would also like to start building our article bank for future issues, so please send any articles to us for review at **bulletin@rcoa.ac.uk** or **gas@rcoa.ac.uk**.

Thank you to everyone who continues to support both publications with their articles. It is great to see indications of some renewed vigour in the recovery from COVID-19.

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COFFEE CLUB: TACKLING TRAINEE BURNOUT

There is a mental-health crisis among doctors in the United Kingdom, with 51% experiencing poor mental health, nearly 50% wishing to reduce their working hours, and 10% planning to quit.[1] There are excessively high levels of burnout being reported among anaesthetists in training.[2] Burnout impacts on the delivery of high-quality patient care,[3] and a 'healthy' work environment is associated with approximately 30% less intention to leave the profession.[4]

In an attempt to prevent burnout in our trainee cohort, we created a regular wellbeing initiative: Coffee Club. We wanted to provide a time and a place in which trainees could reflect on their individual and collective experiences. It was essential that this was a warm, welcoming, safe and confidential space.

Before starting, staff burnout was quantified by conducting wellbeing surveys and monitoring trainee sickness rates. Inspired by a similar initiative run by Dr Tony Allnatt (consultant anaesthetist at the Royal London Hospital), we designed a session during which anaesthetists in training could reflect on their experiences and discuss their emotional responses to stressors. While we are not directly linked to the 'Coffee and Gas' initiative, we also liaised with members of the Association of Anaesthetists who have an interest in wellbeing. A governance structure was designed with clear escalation policies for trainees who

has reduced by two-thirds since the initiative was rolled out, which will undoubtedly have improved patient care.[4] Qualitative feedback from trainees has been overwhelmingly positive. Our project has been adopted by other departments within the trust, and our governance structure has been shared with dozens of NHS organisations nationally.

In conclusion, the data and qualitative feedback collected suggests that Coffee Club is a simple initiative which has improved the wellbeing of anaesthetists in training within our trust at a time when morale in the NHS is very low.

References

1 BMA survey covid-19 tracker survey February 2021. *BMA* 2021. (bit.ly/3k0coDc).

2 Looseley A *et al* for the SWeAT Study investigator group. Stress, burnout, depression and work satisfaction among UK anaesthetic trainees: a quantitative analysis of the 'Satisfaction and wellbeing in anaesthetic training' study 2019; *Anaesthesia* 2019;74:1231-1239. (doi.org/10.1111/anae.14681).

3 Tawfik DS *et al*. Physician burnout, well-being, and work unit safety grades in relationship to reported medical errors. *Mayo Clinic Proceedings* 2018; 93(11):1571-1580). (doi.org/10.1016/j.mayocp.2018.05.014).

4 Developing people for health and healthcare: literature review on nurses leaving the NHS. Health Education England. (bit.ly/3KbMxTm).

5 Mental Health First Aid. (mhfaengland.org).

requested further support. This was ratified by the clinical director of the anaesthetic department before we launched a pilot project in January 2022. This consisted of delivering a 30-minute session, delivered on a fortnightly basis and facilitated by a psychiatric nurse and team of MHFA (Mental Health First Aid)[5] trained anaesthetic staff. The initiative was named 'Coffee Club' to avoid the stigmatisation of concepts such as 'mental health' and 'wellbeing'. Psychological safety was maintained, with care taken over the environment, and over introductions and setting of ground rules. During the sessions, participants are asked to 'be present' without any obligation to speak. Free coffee and pastries are funded through charitable donations. Results and feedback from the initiative have been regularly fed back to the department to ensure that sustained improvements in trainee morale are being achieved and maintained.

Coffee Club has been running for 10 months with excellent engagement – an average of 74% of rostered trainees attended the sessions. Trainee sickness

Table 1 Tips for running our 'Coffee Club' initiative successfully in your department.

Our tips for success	Rationale/Comments
Environment	Psychologically safe space, away from the main department. Circular seating arrangement to promote a flattened hierarchy.
Ground rules	Civility. Confidentiality.
Psychological support	MHFA-trained facilitators and a mental-health trained professional with links to local mental-health trusts/organisations.
Duration	Short and punctual, lasting 30 minutes and starting at 8am, within trainee working hours. Facilitators follow up with 10–15 minute debrief.
Regularity	Fortnightly, so they are regular but not disruptive to workflow.
Feedback	Feedback is obtained at regular intervals to ensure the initiative is meeting trainee needs.
Measuring impact	Conduct wellbeing surveys (such as Warwick–Edinburgh Mental Wellbeing Scales) before and after the implementation, and track trainee attendance/sickness rates as an objective measure of impact. Present data at audit/local faculty group meetings.
Governance	Write-up governance document with escalation policy for trainees in need [contact Dr Wicker for a governance template]. Quarterly faculty meetings to debrief/decompress (with aid of mental healthcare professional).
Funding	Coffee and pastries supplied with charitable funds/trust wellbeing funds. Consultant time paid for through SPA activity.

STARTING AND MAINTAINING THE DIFFICULT AIRWAY RESPONSE TEAM

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Consultant Anaesthetist,
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Difficult Airway Response Team (DART) members*

The Bristol Royal Infirmary's Difficult Airway Response Team (DART), developed in 2017, is a successful, innovative, cross-specialty response unit designed to expedite the arrival of clinical expertise and advanced equipment to the patient's bedside in complex airway emergencies. Five years following DART's inception, we intend to highlight the challenges intrinsic to maintaining the service and how we have attempted to overcome these.

As a tertiary head and neck centre, the Bristol Royal Infirmary undertakes major ENT and maxillofacial surgery daily. The postoperative complications associated with these procedures can be complex and time sensitive. Internationally, DART have been demonstrated to be successful in preventing airway related deaths,[1] but this type of service has not been extensively developed in the UK until now. DART, in the Bristol Royal Infirmary, was developed following four incidents associated with airway complications between 2015 and 2017 which had resulted in serious harm or death. Four *in-situ* simulations were carried out between March and August 2017, and it was noted that at least 40 minutes would pass before expertise was present and a clinical plan was created. Delays resulted from a lack of knowledge of who to contact for senior help, how to contact them, delay in getting specialist equipment, and lack of theatre space when required.

The DART service was established so that in the event of an adult complex airway emergency anyone could activate a 'DART call' via the hospital switchboard to summon specific team members to the location of the emergency. Primary responders include a senior anaesthetist, an ENT doctor, and a maxillofacial trainee. The theatre co-ordinator is also alerted and starts to prepare for the eventuality that a theatre is required. The ENT doctor brings a nasendoscope, and together with the maxillofacial trainee, they contact their respective senior colleagues, who can be off site within a 30-minute travelling radius. Contact details are kept up to date on DART cards that also detail basic airway-emergency management.

As an expert multidisciplinary team, they can formulate a plan and decide on the safest location and method to secure the patient's airway if required. Feedback is collected after every event, and is presented annually at the departmental audit meetings.

Funding was granted in 2018 for a 'DART bag', which contains basic and advanced airway equipment, including a portable video-laryngoscope and a fibreoptic scope. The anaesthetist takes this equipment and emergency drugs. The contents have changed over time in response to national guidance. For example, the COVID-19 pandemic prompted the inclusion of a grab-bag containing equipment for managing tracheostomy emergencies, the National Tracheostomy Safety Project guidelines[2] and PPE. Most recently, surgical equipment has been included in line with the `Management of haematoma after thyroid surgery' consensus guidelines.[3]

The continuous turnover of staff necessitates regular and effective training to maintain a safe service. This is achieved using a multi-modal approach including multidisciplinary team teaching, targeted post-event in-situ simulations, and tea-trolley-style equipment refreshers. Similarly, continuous advertisement of the service is essential for its ongoing incorporation into clinical practice. A combination of posters in appropriate areas, regular inclusion in relevant specialty inductions, and ensuring DART features as the 'message of the week', have all been effective at maintaining service awareness and usage.

DART activity has been monitored since the project's launch in January 2018. There have been 56 calls to date involving a diverse range of airway pathologies. There have been no patient deaths. Two calls resulted in emergency front-of-neck procedures, and 10 patients required transfer to theatre. Assessment of DART calls in the service introduction phase showed mean time from call to definitive management was 44 minutes, with the outlying times being due to the need for awake fibreoptic intubation. To date, the feedback provided has demonstrated improved team working and communication, and suggested and helped to procure essential equipment such as EtCO2 monitoring. It has also highlighted the need for team-member identifiers, and the occurrence of occasional inappropriate DART calls, when a different resuscitation team was needed. This feedback has allowed for continued improvement of the service.

The project demonstrates that hospital-wide cross-specialty teams can be effective at improving interdisciplinary communication and patient care, but the maintenance of such services can present as much of a challenge as their initial set-up. Success depends on continual promotion, adapting to relevant guidelines, actively seeking feedback, and establishing a rigorous timetable for delivering targeted teaching.

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* **Difficult Airway Response Team (DART) members** – DART trainers: Anaesthetic consultants: Penelope Geens, Max Hattaway, Toby Shipway. Anaesthetic SpRs: Amy Dodd, Sarah Todhunter, Carly Webb, Sam Lilliwhite, Helen Murray, John Hickman, Peter Sykes. Oral and Maxillofacial Surgery consultant: consultant: Jacqueline Cox. ENT Consultants: Oliver Dale, Adebayo Ali, Joseph Sinnott. ENT SpRs: Victoria Harries, Ahmad Barjus, James Constable, Shilpa Ojha, Salma Mohammed. ANPs: Andrew Hill, James Daley. Enhanced Recovery After Surgery (ERAS) lead: Michelle Brack.

DART bag and equipment brought to DART call by anaesthetic team. Noticeable are portable video laryngoscope, portable end tidal capnometer and additional PPE.

5-MINUTE FLASHCARDS: THEATRE-TEAM TRAINING

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A recent high-profile death due to undetected oesophageal intubation has raised awareness of this Never Event, and a huge amount of beneficial training has emerged. Our trust not only participated in the subsequent international campaign, but also built on this by creating our own local platform, which has been integrated into theatre practice and designed to take only five minutes away from precious theatre time.

Background and inspiration

Following the avoidable death of Glenda Logsdail, the coroner issued a 'Prevention of future deaths' report.[1] This outlined explicit actions to be taken nationally and triggered a powerful campaign driven by a collaboration between the Royal College of Anaesthetists, the Difficult Airway Society and the Association of Anaesthetists.

The output of this campaign included an educational video ('No trace = wrong place')[2] and 'Unrecognised oesophageal intubation' flashcards.[3] These flashcards took only five minutes of theatre time, and aimed to address two key issues: to increase awareness of capnography, and to empower all team members to speak up and challenge in a crisis. Crucially, the flashcards were designed to be discussed among the whole theatre team, not just anaesthetists and anaesthetic assistants.

The phrase 'those who work together should train together first appeared in a House of Commons Health Select Committee report in 2009,[4] and was attributed to the Clinical Human Factors Group. Since then, it has appeared in several important publications, including NHS England's *National safety standards for invasive procedures*[5] and *National maternity review*.[6] Meanwhile, regular, multidisciplinary team training is one of the standards for the RCoA's *Anaesthesia Clinical Services Accreditation* (ACSA) scheme[7] and is recommended by the *Guidelines for the Provision of Anaesthetic Services* (GPAS).[8] Pressures on theatre time mean that training together as a theatre team can be a challenge for departments to deliver.

Our hospital's actions

At Gloucestershire Hospitals NHS Foundation Trust, the 'Unrecognised oesophageal intubation' flashcard

campaign was successfully rolled out. Feedback included comments such as:

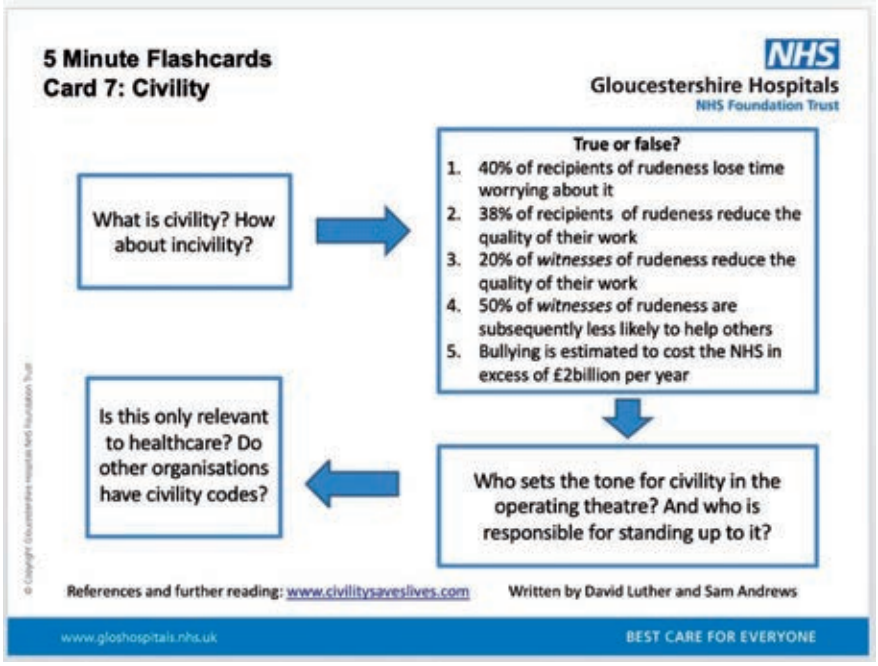
- 'More please!'
- 'A weekly flash card sim would be beneficial'
- 'Breaks down barriers, allowing all staff to speak up'
- 'Good to stimulate discussion'
- 'Surgical consultant educated on where to find emergency bell!'

Inspired by this feedback, we developed 'five-minute flashcards' with the aim of integrating regular multidisciplinary team training into our theatre routine, of improving knowledge and teamwork, and of ultimately enhancing patient safety. We discussed the concept with our local leads for anaesthesia, surgery and theatres, and their support helped hugely with implementation.

The flashcards are discussed once a week at the WHO morning brief with all members of the team present. The flashcards cover a range of topics relevant to the whole team. The content can be technical (eg, surgical site infections) or non-technical (eg, civility). They are designed to be interactive, light-hearted in places, and to stimulate discussion. Theatre teams are encouraged to start a timer and stop discussion after five minutes whether they have finished the card or not, and to go off topic if they want.

The first five flashcards were distributed and discussed in our theatres (24 theatres across two sites) over a five-week period in May and June 2022. The first flashcard was discussed on a Monday morning, the second on a Tuesday, and so on. We produced and discussed further sets of five flashcards over five-week periods in July/August and September/October. All 15 flashcards can be seen by the QR code below.

Image Example flashcard



While earlier ideas for flashcards were brainstormed by our team, we have increasingly been contacted by members of the theatre teams requesting topics. For example, our trust recently carried out a major-incident planning exercise, and a flashcard on 'handling evidence' was produced to coincide with this. Flashcards have been written by nurses and doctors, consultants and trainees, and anaesthetists and surgeons.

We believe the benefits of the discussions are not only acquisition of knowledge from the content of the flashcard, but also the improved teamworking and flattening of hierarchy that come from the discussion itself, regardless of what is discussed. Please get in touch if you would like tips on developing 5-minute flashcards in your trust!

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7 Anaesthesia Clinical Services Accreditation Standards. *RCoA* (bit.ly/3QBrYjH).
8 Guidelines for the Provision of Anaesthesia Services. Chapter 1: The Good Department. Recommendation 3: Education and Training. *RCoA*. (rcoa.ac.uk/gpas/chapter-1).

Scan the QR code to access the 5-minute flashcards or go to the website at: gloshospitals.nhs.uk/gps/5-minute-flash-cards

Access the RCoA flash cards on unrecognised oesophageal intubation on our website at: bit.ly/RCoA-IntubationFlashCards

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Life and work: training the scenic way

'How many?', 'Yes, four children'. I usually feel a bit like a freak of nature at this point in the conversation. Cue jokes about anaesthetists hating odd numbers or the efficiency of having children in pairs.

So I'm a medic turned anaesthetist turned dual ICM trainee with two sets of twins; I toddled off to medical school more than 20 years ago and have been 'in training' ever since. It is hard, but life is hard and this isn't about how I've overcome immense odds and struggled through, but about how children and the scenic career route have made everything better.

I have been a doctor for a long time for a trainee; I wore a white coat on the wards as a student, and standard VTE prophylaxis wasn't a thing when I qualified. Being less-than-full-time means that technically I'll be at work for exactly the same number of days as a full-time trainee, but the passage of time and the ability to reflect and consolidate does seem to mean that the experience adds up to more.

I was listening to one of the consultants who helped start me on my career in anaesthetics giving a lecture the other day. He was making a point: '... in my 30 years as a doctor, 15 as a consultant...'.

A quick bit of maths and I realised that my training pathway was only going to be one year longer than his. The pillars of our departments, the consultants we look up to, weren't on a training pathway that took you from newly-qualified to consultant in nine years. This is a new thing, new enough that I'm in only the second year to do the foundation programme from the beginning, and I remember the general belief that 'medical musical chairs' was going to be an utter disaster. People who have taken more than nine years to complete training are still very much the majority in the NHS.

My presence at home for an extra two days a week is good for the children, but, more importantly, I have that time to get excited about seeing a tractor, looking at wild flowers, or learning about things not on an exam syllabus. A child's life is so full of wonder and joy, something we lose as we get older, but spending time with children allows you the privilege of seeing into that world again. We oversee so much misery and suffering at work; as an ST7 in a major trauma centre I've lost track of the number of families I've talked to about the untimely death of their loved one – who is often much younger than me. I feel their loss more keenly and I hope it makes me more empathetic and compassionate, but when I get home there are four little people who are so genuinely delighted to see me that I can let go.

Prior to having children, I found paediatrics quite difficult; I didn't know what to do with these small alien type things coming for an anaesthetic. Once I learnt how to relate to a child, I discovered how much I enjoy paediatrics and revel in the challenge of trying to get every child through their anaesthetic without tears (obviously far from a 100% success rate but that is part of the fun). I can also talk to their parents better because people aren't always very good at articulating their worries and anxieties, and having some idea where they are coming from helps.

Exam revision around small children is far from fun, and I did feel rather guilty about the time I wasn't spending with them. One day I bemoaned to my husband that it was completely impossible, and that I was never going to pass the FRCA. He replied 'OK, become a staff grade then' (he is a physicist and brutally logical). I thought about it and realised that I had put so much effort into my exams that I didn't want to give up without trying. It was an important change in mindset from one that exams were something I had to do, to one that they are something I wanted to do, and that the world wouldn't end if I didn't pass.

I definitely believe I am a much better doctor than the one I would have been if I got my CCT in 2016. I hope I've managed to give reassurance to someone thinking about children and a career that not only is it possible, but that it is an idea with very many merits. I'll leave you with a quote from a senior trainee to me when I was an SHO – 'You are never going to get to the end of your career and wish you'd become a consultant that little bit earlier, but you might just wish you'd spent more time with your children'

PQIP Perioperative Quality Improvement Programme

pomVLAD near real-time reporting of risk-adjusted postoperative morbidity outcomes

Continuous morbidity monitoring to improve postoperative outcomes

Dr Rachael Brooks and Dr Eleanor Warwick,
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Dr James Bedford, former PQIP fellow and Consultant Anaesthetist,
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Professor Ramani Moonesinghe, PQIP Chief Investigator

In 2023, the Perioperative Quality Improvement Programme (PQIP) is launching new postoperative morbidity variable life adjusted display charts (pomVLAD) for all sites recruiting patients undergoing colorectal surgery. Having previously been run as a pilot study in 10 hospitals, the quality-improvement dashboard has been refined and will now provide all sites with near-real time, risk-adjusted morbidity monitoring accompanied by the display of a number of key enhanced-recovery quality-improvement (QI) targets.

For sites recruiting patients of other surgical specialties, there is also a newly developed QI dashboard which does not incorporate risk-adjustment. Dr James Bedford explains how they can be used to stimulate QI initiatives in your local hospital.

The impact of postoperative morbidity

Death following major elective surgery is rare, but major complications occur in up to 15% of surgical inpatients. In the PQIP cohort, which is particularly high-risk, the inpatient complication rate is 25%.[1] Complications increase hospital length of stay and predict reduced long-term survival and worse health-related quality of life.

PQIP collects multiple perioperative process and outcome measures with the aim of supporting both research and local QI.[2] The rollout of pomVLAD will support local teams to identify both positive and concerning trends in postoperative morbidity more rapidly than traditional analyses that incorporate risk-adjustment; this invaluable information will enable more timely investigation of current care processes and support local QI to improve patient outcomes.

Continuous, risk-adjusted reporting of postoperative complications

Variable life adjusted displays (VLADs) were originally developed to monitor observed against expected mortality after cardiac surgery. They are now widely used across medicine and surgery. A VLAD can be utilised for any short-term outcome such as postoperative complications. The VLAD chart shows how many fewer (or more) complications there are over time compared to what would be expected based on a risk-adjustment or risk-prediction model.

PQIP's pomVLAD calculates the expected risk of postoperative morbidity for each individual patient using the PQIP-Colorectal risk (CR) model developed from a cohort of 11,646 colorectal patients.[3] The model includes 12 PQIP variables, and it performed favourably compared to existing morbidity risk-prediction models. pomVLAD monitors morbidity at postoperative day 7 using the Postoperative Morbidity Survey (POMS).[4]

The VLAD chart plots the predicted risk of morbidity (based on the PQIP-CR risk model) minus the observed outcome for each consecutive patient. Upward trends in the VLAD are positive (lower observed postoperative morbidity than expected),

downward trends are negative (higher observed postoperative morbidity than expected) (Figure 1).

Using pomVLAD to support QI

The new pomVLAD dashboard also includes easy-to-interpret displays which represent 10 PQIP-recommended enhanced-recovery (ER) processes. The proportion of patients DrEaMing (Drinking, Eating and Mobilising) on postoperative day 1 is shown alongside a range of pre-, intra- and postoperative ER measures which sites can focus their QI efforts on (Figure 1). DrEaMing by postoperative day 1 is associated with reduced hospital length of stay and fewer later complications.[1] Patients with nasogastric tubes or abdominal drains in recovery, those who had epidurals inserted for surgery, or those with moderate or severe pain in recovery are all less likely to DrEaM postoperatively.

pomVLAD charts are now available for all PQIP sites recruiting colorectal patients. Local investigators involved in the pilot study found the dashboard intuitive to interpret and felt it was helpful for the identification and monitoring of QI projects. To get the most out of pomVLAD or our new dashboards for non-colorectal surgery, PQIP at your hospital should be recruiting as many patients as possible and entering the data as close to the time of surgery as possible. Focusing recruitment efforts on a single specialty or small number of specialties may be most rewarding for your team and your patients. Positive, multidisciplinary collaboration is vital for sustainable QI. We invite you to share your pomVLAD dashboard with your colorectal perioperative team to help engage them and focus your combined QI efforts.

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4 Grocott MPW *et al*. The Postoperative Morbidity Survey was validated and used to describe morbidity after major surgery. Journal of Clinical Epidemiology 2007; **60(9)**:919–928. (bit.ly/3XTjpUp).

Where can I find more information?

PQIP website
pqip.org.uk

PQIP Collaborative Conference 2019 – pomVLAD
youtube.com/watch?v=Toc7GeRNhJY

pomVLAD blog
pomvlad.blog

The Health Foundation – Innovating for Improvement – pomVLAD
bit.ly/3I83XOk

Scan the QR code for more information and advice on how to use the pomVLAD for your QI projects.

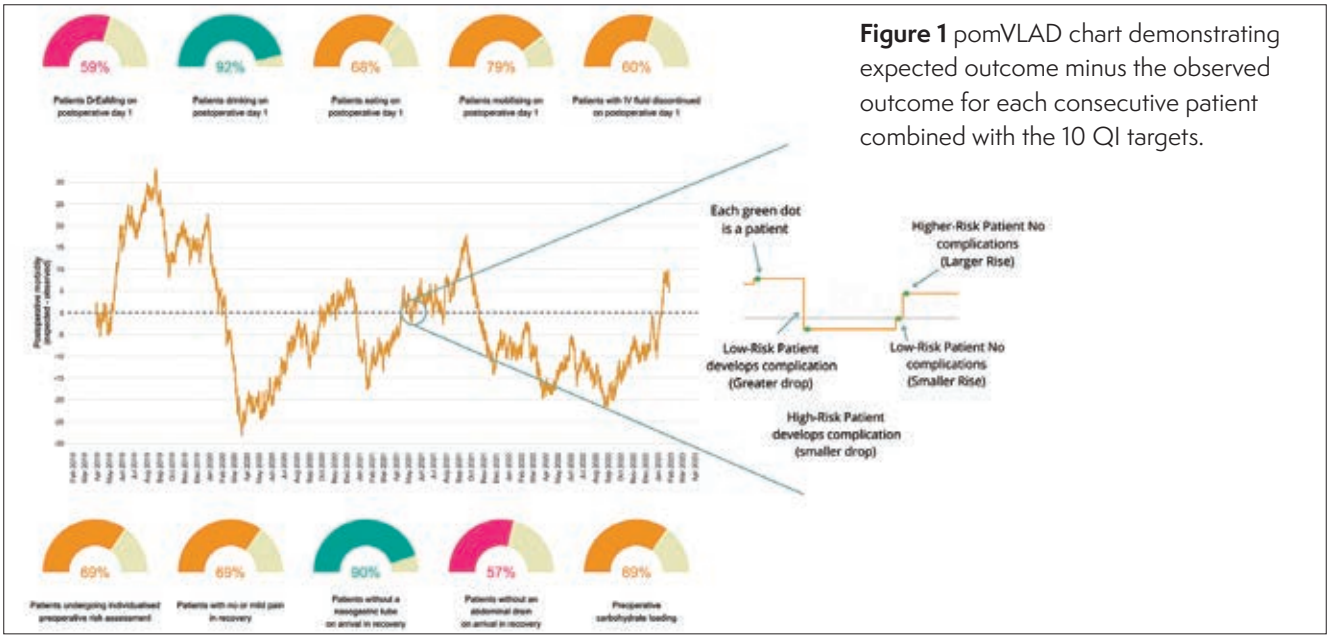

Figure 1 pomVLAD chart demonstrating expected outcome minus the observed outcome for each consecutive patient combined with the 10 QI targets.

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With thanks to the RCoA's Patient Voices focus group and the perioperative thoracic team at University College Hospital NHS Foundation Trust.

PQIP Perioperative Quality Improvement Programme

The patient as an advocate for DrEaMing

The 'DrEaMing' care bundle supports patients to Drink, Eat and Mobilise within 24 hours of major surgery. This simple, patient-centred intervention is associated with decreased length of stay for patients and a lower rate of late postoperative complications.[1]

Supported by the RCoA and Getting It Right First Time (GIRFT), DrEaMing is a Commissioning for Quality and Innovation (CQUIN) indictor, and was recently updated for 2023/2024. Containing the core features of more complex enhanced recovery pathways, DrEaMing aims to revitalise the quality-improvement (QI) efforts aiding patients' recovery after surgery.

A positive collaborative culture, with cohesive working between the whole surgical multidisciplinary team, is essential for DrEaMing to become a sustained standard of care. The perioperative team are fundamental in delivering DrEaMing, but the other important party that can drive QI are the patients themselves!

The RCoA patients' voices perspective

At a recent focus group, members of PatientsVoices@RCoA unanimously agreed that DrEaMing is an empowering and humanising quality metric. Being able to drink, eat and mobilise are basic and fundamental human activities that help patients feel more normal and 'on the road to recovery'.

Counselling patients that DrEaMing is expected on day one after surgery gives patients a realistic and empowering goal to aim for and reassures them that their care is not being 'fast tracked' due

to hospital pressures. Patients want to do anything to avoid complications and prolonged hospital admissions, but need to know the care they are receiving is evidence-based and patient-centred. Educating them in the daily steps after surgery, including DrEaMing, gives patients the ability to be actively involved in their own postoperative recovery and facilitate a return to their everyday lives.

An example of perioperative patient empowerment and education

The thoracics team at University College Hospital London have created a streamlined perioperative pathway that is educating and thus empowering for their patients. Headed by resourceful clinical nurse specialists, a multimedia approach with a consistent message is utilised to educate patients early about what to expect in the postoperative period and reinforce why enhanced recovery pathways will aid their postoperative recovery, getting them home more quickly and with fewer complications. Patients' understanding and retention of information is enhanced when provided by interactive communication with their clinical team and then reinforced by printed information,[2] and these methods are utilised by the team.

The perioperative education is reiterated through a two-stage preoperative assessment with an emphasis on consistent and timely information sharing. Firstly, patients receive an educational telephone consultation with a paper-based information pack. A face-to-face assessment 96 hours prior to surgery then reinforces the education about their postoperative expectations, providing patients with the tools to be actively involved in their own recovery. A postoperative diary bridges recovery in hospital to home, with daily check-ins for post-surgery symptoms and a checklist of activities to be achieved, such as DrEaMing, distance mobilised and breathing exercises. Co-designed with patient and the multidisciplinary teams' feedback, the enhanced recovery pathway is continuously adapted. Core to the teams DrEaMing and enhanced recovery success is their nurturing of their change champions, multidisciplinary collaboration, and their iterative reflection on how they can better deliver their patient care.

Conclusions

Enhancing patients' understanding of their own disease process and treatment improves shared decision-making, patient involvement, and health outcomes, while also reducing their anxiety and stress around surgery.[3] Well informed and prepared patients with knowledge of their planned care feel safer and are more prepared, both physically and mentally, to participate actively in their self-care and recovery.[2] Demystifying patients' postoperative journey through education helps make the future familiar and optimises compliance with recovery goals.

Research conducted through PQIP indicates that appropriately counselled and educated patients will ask the right questions after surgery, helping them with self-efficacy and self-management, driving their own recovery, and resulting in truly patient-centred care. Patients will have a clearer understanding of why interventions are happening at each stage, and with understanding comes empowerment. Empowerment to ask, 'When am I getting out of bed?' or 'Why am I not DrEaMing?' makes patients themselves powerful drivers for QI. Beyond DrEaMing, this empowerment can be harnessed to support any perioperative QI metric, as informed patients are more likely to be proactively involved in managing their recovery.

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Where can I find more information?

Commissioning for Quality and Innovation 2022/2023 guidance (bit.ly/3XCRGaj)

Commissioning for Quality and Innovation (CQUIN) – Getting It Right First Time – GIRFT (bit.ly/3S8725w)

Patient perspective: DrEaMing (drinking, eating and mobilising) after surgery – RCoA *Bulletin* (bit.ly/3IstwLf)

Perioperative Quality Improvement Programme (PQIP): Working with a dream-team – RCoA *Bulletin* (bit.ly/3IK3Cdb)

Watch our recent DrEaMing collaborative webinars by scanning the QR Code.

Entrustment decision-making: a collaborative trainee and trainer perspective

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The concept of entrustment is as ancient as apprenticeship. Anaesthetists reeling from the effects of the pandemic are adjusting to the logistics of the new curriculum, and with it a paradigm shift in workplace-based assessment.

Cynics may well have thought that it is all a rebranding exercise, yet it is a considered outcomes-based holistic approach to training. The old 'tick-box' process has been replaced by qualitative faculty judgements of capability, anchored to more clearly articulated learning outcomes. Progression is explicitly framed around increasing practice autonomy through 'entrustment' of responsibility for patient care. Entrustment-based assessment moves beyond the spiral curriculum and being 'good enough', replaced instead by promotion of the ideal of an excellent all-round professional anaesthetist.

The supervision/entrustment scale (Figure 1) is a judgement of future capability, and a model to deciding how far to trust trainees to carry out patient care on their own by aligning assessment in the workplace with everyday clinical practice. The new assessment strategy incorporates these levels alongside supervised learning events (SLE) as part of the more important developmental conversation, formalising previously informal assessments of competence (such as feeling able to go for coffee). It requires assessors to interrogate their 'gut feelings', making it an overtly conscious decision and thereby enabling them to explain the reasoning and contextualise the decision-making process to their trainee, considering the required supervision level if the trainee were to repeat the procedure here and now. Underpinned by the generic

professional capabilities, this exposes the hidden learning to trainer and trainee.

As adult-learners with significant experience of personal education and clinical practice, trainees need the opportunity to demonstrate or develop the required behaviours to be entrusted. Contextualising entrustment is difficult and is influenced by several factors, including the educational environment, educator expectations, learner needs, cultural expectations, patient requirements and circumstance. By considering the qualities of agency, reliability, integrity, capability, and humility,[1] the assessor and the trainee may identify areas to work on to enhance their 'entrustability' and professionalism.

There are a number of ways trainees may actively engage to make entrustment meaningful, and trainers can signpost them to areas they can develop.[2] The learning conversation is a great place to do this, as it is no longer a top-down approach but rather a two-way reflexive dialogue facilitated by the trainer and enabled by the trainee. Informed by a supervisor's observations of a learner's behaviours in practice, it supports the trainee strategically by taking stock of where they are at in a mature way, with safety always at the core, and with the intent of improving future performance. It utilises feedback and debriefing skills in an open and meaningful shared conversation.

Entrustment tips

- Engage early – ideally email/ conversation prior to the list to establish roles/goals. Especially helpful if you are not well known.
- Establish your skill base – convey experience level, procedure numbers, and information from multiple sources.
- Acknowledge trust explicitly – identify opportunities for 'mini-entrustments'[2] – these are especially important if working with reducing supervision.
- Make plans – and acknowledge factors influencing the day.
- Don't ignore the elephant in the room – when things don't go to plan, acknowledge the obvious, and align your thoughts with your supervisor.
- Quick SLE sign-off – immediately or send within 24 hours – ensure you generate action points.
- Bear in mind your presence in a department is not just clinical; engaging in other activities may enhance your credibility.
- Seek advice – from excellent trainees, educational supervisors and other mentors. Take time to say thank you when their advice has been successful.

Trainees have professional ownership of their experience, with the trainer as their guide. As with all change, terminology abounds and concepts are new, yet in practice the new curriculum has honourable goals for the professional adult-learner that will take time to integrate. The new assessment strategy better complements the nuance and complexity of professional maturation through training and development of generic professional capabilities. Trainers are striving to promote holistic development of doctors in training and to maximise training opportunities. Trainees may actively engage with entrustment through meaningful learning conversations, and by developing a personal tool kit that may be utilised across their practice and enhance all training domains.

References

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Figure 1 RCoA supervision levels

1	Direct supervisor involvement – physically present in theatre throughout.
2(a)	Supervisor in theatre suite – available to guide aspects of activity through monitoring at regular intervals.
2(b)	Supervisor within hospital for queries – able to provide prompt direction/assistance.
3	Supervisor on call from home for queries – able to provide directions via phone or non-immediate attendance.
4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols).

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SEAUK

Society for Education in Anaesthesia UK (SEAUK)

Discrimination: an issue for anaesthetists in training?

With the rise of the Black Lives Matter and #MeToo movements in the last few years, media attention has been drawn to the abusive behaviours that have become embedded in our culture. Under the Equality Act 2010, it is against the law in the UK to discriminate against anyone because of nine 'protected characteristics'. These are race, age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, religion or beliefs, and sex and sexual orientation.

A survey among doctors and medical students highlighted that 76% had experienced racism in the work place at least once in the previous two years.[1] Similarly, 91% of woman doctors in the UK have experienced sexism at work,[2] and a survey among European surgeons revealed that 20% had considered quitting their job due to discrimination.[3] While surgery is a specialty where discrimination and harassment concerns have been well documented, these issues have not been explored widely among anaesthetists.

In April 2022, I conducted an anonymous survey to explore the experiences of trainees within the Warwickshire School of Anaesthesia, asking if they were subject to any type of discrimination from patients or other staff members, and if so, what had been the impact on mental health, performance at work and career progression. I also asked if incidents were being reported appropriately.

Trainee's perspective

In total, 58 trainees responded (response rate 44%) to the survey. They were asked to describe frequencies and details of discriminatory behaviour experienced against the protected characteristics in turn. I enquired separately about incidents arising from patients and from members of staff.

Concerningly, incidents of discriminatory behaviour were reported against all protected characteristics, with race and gender discrimination being the most commonly reported. Nearly 40% of respondents said they had experienced racial discrimination from patients, with 29% reporting incidences from staff. 40% reported incidences of gender discrimination from patients and 36% from staff members.

Age discrimination from patients was reported by 24% of trainees, with multiple examples of doctors being perceived as being too young to provide their care. 14% reported incidents from members of staff. 9% of respondents reported discrimination against pregnancy or maternity leave from patients, with 12% reporting incidents of discrimination from staff. 19% reported religion or beliefs as a cause of discriminatory behaviour, with staff implicated in 16% of responses.

Quotes from trainees

'Patient asked me to leave theatre because of my skin colour; the consultant asked if I'd leave the theatre until the patient was under general anaesthetic.'

'Referred to as a "girl" when I am an adult woman.'

'During pregnancy, occupational health advised me not to do interventional radiology. The vascular lead said I couldn't sign off the module. No solution proposed.'

'I'm catholic and felt pressure to do the termination of pregnancy list.'

'A consultant asked a colleague whether the locum registrar for the night was white or Asian, stating the latter would be less preferable'

Impact

Often, repeated exposure to discrimination has clear and far-reaching effects. 24% reported effects on their performance at work, while 21% stated that it had impacted negatively upon their mental health. Almost a quarter said that discrimination had negatively impacted their career progression and, worryingly, 9% had considered leaving their post.

'Comments can cause anger, tunnel vision and lack of focus. I required mental health support a year later. The consultant brushing it under the carpet made me question my ability.'

'Due to my gender and ethnicity, I am not taken as seriously as white/male colleagues. I feel that I must do twice as much to be considered on par.'

'I wanted to quit numerous times. Always feel the need to prove myself.'

Are trainees supported?

Only 9% of those who experienced discrimination reported an incident, of whom just 11% felt it had been appropriately addressed. One respondent sought support from a College tutor. No trainees chose to approach an educational supervisor.

'Don't want to be seen as a troublemaker'.

'Wouldn't have made any difference'.

'I was a novice trainee, didn't have confidence to report'.

Suggestions from trainees for improvement included support groups, anonymous reporting systems, mandatory face-to-face staff training, challenging unacceptable behaviour, improving support networks, and training of the education supervisor workforce to raise awareness.

Finally

This insight into the experiences within our school of anaesthesia may well be echoed across the UK. The results raise not only the issues of racism and sexism as highlighted by previous surveys, but also the widespread discrimination in terms of other protected characteristics. With trainees reporting significant impacts on their mental health, performance at work and career progression, we need effective strategies to raise awareness, reduce the incidence of discrimination and support individuals affected.

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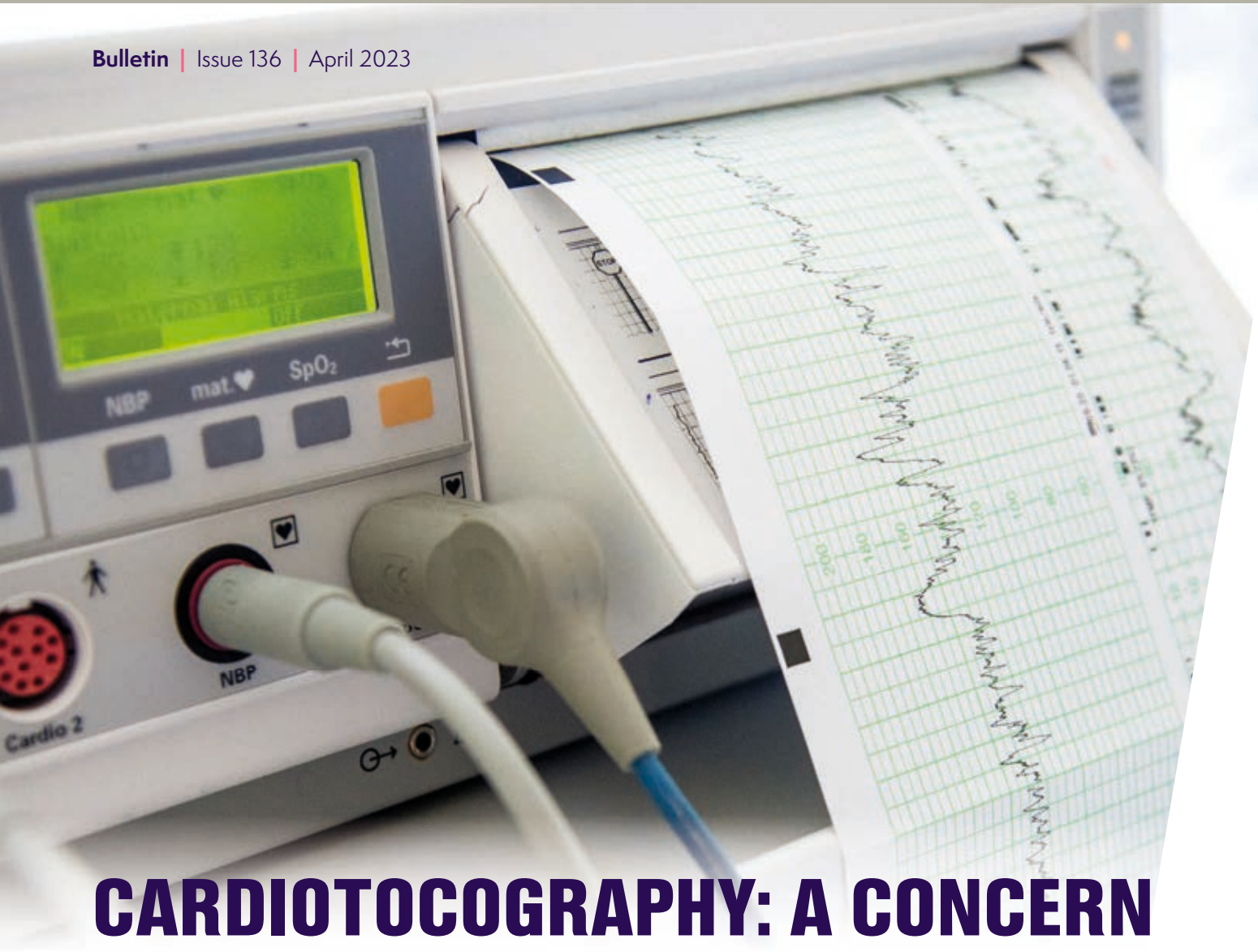
3 Holzgang *et al*. Discrimination in the surgical discipline: an international European evaluation (DISDAIN). *BJSOpen* 2021;**5(3)** (doi.org/10.1093/bjsopen/zrab050).

This survey was partly presented as an abstract at Winter Scientific Meeting of Association of Anaesthetists, London, 12–14 January 2023.



CARDIOTOCOGRAPHY: A CONCERN FOR THE ANAESTHETIST?

Dr Simon Apps
ST6 Anaesthesia,
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Dr Vinod Patil
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Cardiotocography (CTG) to monitor foetal heart rate is frequently used on the labour ward to monitor for foetal distress. Interpretation of CTG is routinely undertaken by the obstetric and midwifery teams to guide labour interventions, along with the mode and urgency of delivery. Anaesthetists are a key member of the multidisciplinary team, and we should therefore understand CTG. This knowledge can then help with joint decision-making, provide an additional set of eyes observing for foetal distress, and be an aid for choosing an anaesthetic technique.

Current training

The 2021 curriculum mentions CTG knowledge in both Stage 1 and in the Obstetric Anaesthesia Specialist Interest Area.[1] However, there is a lack of clarity on how to obtain it. Despite there being excellent resources available for anaesthetists to learn about CTG interpretation, it is not formally taught or assessed.[2] It is left to the individual anaesthetist in training to obtain this knowledge, creating a lack of consistency in knowledge among anaesthetists.

Practical applications

Category 1 caesarean section

The CTG is reviewed as part of the anaesthetic assessment. The findings are then discussed with the obstetrician to establish if regional anaesthesia is suitable. This could potentially avoid general anaesthesia along with its risks, improving patient safety. It allows for more precise and analytical decision-making, scientifically considering which mode of anaesthesia to deliver

Epidural insertion

CTG is a blind spot for many practising obstetric anaesthetists delivering an epidural because it is not part of their decision-making. Epidural causes an element of sympathetic block which can lead to hypotension and negatively affect the CTG, potentially triggering an emergency caesarean section. A poor CTG could be discussed with the obstetric team, the stage of labour considered, and a cautious top-up given. This could prevent a traumatic experience for the patient and improve patient safety.

Additional safety layer

The Ockenden review has highlighted issues with maternity care, and there is currently a national shortage of midwives caring for increasingly complex patients. We can provide a pair of fresh eyes to look at the CTG and may notice abnormalities that have been missed. Many women in labour request an epidural prior to seeing an obstetrician. It helps the obstetric team to know someone else is reviewing the CTG, adding further credibility to our specialty.

Our survey

Being aware of this knowledge gap, we have carried out a short local survey of the obstetric anaesthetists practising at Queen's Hospital, one of the largest obstetric units in the country with more than 10,000 deliveries per year.

The questions asked and the responses to our survey are highlighted in Figure 1. The survey demonstrates that there is a lack of confidence in interpreting CTG among anaesthetists and that few had received any formal training, yet there is agreement that anaesthetists should be able to interpret CTG. Given that CTG can impact on the choice of anaesthetic technique, it is imperative that obstetric anaesthetists have some interpretation abilities. Previous surveys have shown similar results, however there still is no national consensus on how this teaching should be delivered or assessed.[3,4]

Figure 1 responses to our survey

	Yes (%)	No (%)
Would you feel confident interpreting a CTG?	19	81
Have you ever received any formal training on CTG interpretation?	19	81
Would you like to receive formal training on CTG interpretation?	81	19
Do you think anaesthetists covering labour ward should have some knowledge of CTG interpretation?	90.5	9.5
Have you ever performed a general anaesthetic over regional anaesthesia for ceasarean section because the obstetric team had CTG concerns?	76.2	23.8
Do you feel having the ability to interpret a CTG would aid you in discussions about patients with the obstetric and midwifery teams?	71.4	28.6

The future

If anaesthetists have a basic understanding of CTG and utilise this as part of their standard practice, we will further elevate our role as perioperative physicians on the labour ward from being more of a technical specialty. Understanding CTG allows a dialogue with the obstetricians and helps to provide a precise form of anaesthesia instead of 'panic' anaesthesia in an emergency.

While the decision-making must remain the responsibility of the obstetric team, a good understanding of the CTG will allow us to take a full part in their decisions.

We suggest that there should be dedicated teaching and assessment to demonstrate understanding of CTG. This could include formal examination as part of the FRCA, for example as data interpretation in the primary OSCE or as part of a long-case in the Final SOE.

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1 Curriculum for a CCT in Anaesthetics, *RCoA*, 2021. (rcoa.ac.uk/2021-anaesthetics-curriculum).

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3 Jafri S *et al*. Survey of CTG interpretation and training amongst obstetric anaesthetists (bit.ly/3EednX9).

4 Aseri S *et al*. Do trainees doing obstetric anaesthesia module need to know about cardiotocography? *Regional Anesthesia & Pain Medicine* 2007;**32**:75.

MEET YOUR NEW COUNCIL MEMBERS

DR CHRIS TAYLOR

Elected member,
Consultant representative

Why did you run for Council?

I hope to work with Council colleagues on the Education, Training and Examinations Board to help develop the FRCA exams following the recent Exam Review and with specialist societies to improve and formalise subspecialty training.

What do you do outside of work?

I enjoy cycling, park runs and skiing.

I live in Surrey with my wife, Clara and daughter – both are currently studying medicine.

If you didn't work in anaesthesia, what would you do?

It's difficult to be certain, but if I'd remained in medicine I expect I'd have stayed in paediatrics and probably would be a consultant in PICU. Otherwise, I would imagine that I would be a research scientist.

DR CATHERINE BERNARD

Elected member,
Anaesthetist in training representative

Why did you run for Council?

I ran for the Council because my route through training has been quite circuitous and unusual and fused with some personal misfortunes; I believe that provides me with unique experience. I hope to guide others through the more unusual or challenging pathways of anaesthesia. As Stephen Covey said, 'strength lies in differences, not similarities'; I am keen to promote that ethos at the College.

What do you do outside of work?

Outside of anaesthesia, I like to do some light (non-triathlete level) cycling, and I continue to attempt to create an indoor jungle by building upon my collection of more than 45 houseplants, all combined with a love for (too much) food....hence the cycling.

If you didn't work in anaesthesia, what would you do?

If I wasn't an anaesthetist, I would probably be an interior designer. My best purchase to date has been a 1960s boat-shaped bar. Drinks ahoy!

DR CHRIS CAREY

Elected member, Consultant representative

Read more about Dr Chris Carey who has been re-elected for a second term on page 32.

We are delighted to announce that since September 2022 we have welcomed new elected and co-opted Council members.

The main purpose of Council is to provide clinical leadership to the specialty, set standards for education, learning and examinations, and ensure adherence to evidence-based practice.

It is the role of Council members to make sure that the College represents the needs of members and the profession. Find out more about new Council members below.

DR MATT TUCK

Co-opted member,
Anaesthetist in training representative

Why did you run for Council?

I had always been involved in representative groups throughout school, university, and during clinical practice through the BMA. Driven by a strong belief that if you don't like something then be part of fixing it, I saw a chance to be part of the solution to some of the more recent events that have impacted on anaesthetic trainees' lives. Curriculum, exams, communication and leadership were all examples of where the humanity and compassion of those at the College just didn't filter down to the jobbing and training anaesthetist, and of where I could help drive a change to fix that.

What do you do outside of work?

Outside of work I run, cycle and tend to a shabby allotment where I spend countless hours in the summer and get regularly shown up by octogenarians. When time permits, I also explore the hills and beaches of the north-east coast. I own a piano that sadly gathers dust all too often.

If you didn't work in anaesthesia, what would you do?

If I didn't work in anaesthesia I would have loved to work in engineering, working outdoors seeing big projects come together. I think I would get immense satisfaction from building something people make use of every day.

DR GIOVANNA KOSSAKOWSKA

Co-opted member,
Anaesthetist in training representative

Why did you run for Council?

Getting through core training cost me a lot, both financially and emotionally. When I returned to the training programme after spending time as a locally employed doctor, I did so with a bitter view of the College – never did I see myself getting involved with the work that it does! When, however, it moved to increase representation of anaesthetists in training on Council, I thought the opportunity to share my own experiences as a trainee at such a high level was too important to pass up. In my short months on Council, I've been made to feel welcome, with my views valued. There's plenty of work to be done – I'm constantly amazed at how much Rashmi and Sarah were taking on with such effortlessness before the two seats were expanded to four.

What do you do outside of work?

At the moment, I'm trying to relearn the art of reading for pleasure. I've recently discovered that book-buying and book-reading are two entirely different hobbies, and now that I'm free from exams I need to tackle the stacks of novels I've collected over the years! I'm also an active member of our local rescue-greyhound owner group, which means there are always walks to be had with our long dogs!

If you didn't work in anaesthesia, what would you do?

The dream is to be an oenologist, with a hybrid vineyard-ranch located deep in Andalusia, teeming with Iberian horses and rescue-sighthounds. Strong SPF an absolute must.

Additional support for anaesthetists in training

In addition to the newly elected and co-opted anaesthetists in training on College Council there are a number of other individuals who, through their roles within the College, work directly on behalf of anaesthetists in training.

Dr Chris Carey

Elected Council member; Chair of the Education Training and Examinations Board

I have been chair of the Education Training and Examinations (ETE) Board since 2019. In addition to my work on Council, I have experience of working in a number of training roles, having previously been College tutor and head of school and being currently an associate postgraduate dean in the Kent, Surrey and Sussex Deanery.

The ETE board manages College activity relating to training, the curriculum and the FRCA exam. It also oversees the College's workforce committee and its activities. We have been very active over the last few years in the pursuit of additional training posts, something that has proved challenging. We know that there is considerable demand for both consultants and training posts, in particular at ST4. Ensuring that anaesthetists can secure the training that they need to obtain a consultant post remains our number-one priority.

The ETE board is also responsible for overseeing the development of the FRCA exam. The findings from the recent internal and external reviews are being used to guide development of the format and processes of College exams. We aim to ensure that our exams reflect current practices and training, and meet optimal standards in postgraduate medical assessment.

My various roles keep me very busy but I am always happy to be contacted via the training team email at: training@rcoa.ac.uk.

Dr Sarah Thornton

Elected Council member; Deputy Chair of the Education Training and Examinations Board

I'm Dr Sarah Thornton, a critical care and anaesthesia consultant based in Bolton. I work full time, have three kids (18, 21 and 24 years) and intermittent guide dogs that I foster while they are training. I have been on Council since March 2022.

I am deputy chair of the Education, Training and Examinations (ETE) Board. Before this, I was head of school and training programme director for Manchester and Mersey, looking after more than 500 trainees for eight and six years respectively.

I have a massive interest in wellbeing, EDI and differential attainment; I have tried my best to foster innovation in those areas in the North West, and I am bringing that viewpoint to the table at the variety of committees that I serve on. I'm on the Fighting Fatigue group and have just joined as the College representative on the working party for sexual misconduct in surgery.

My remit from the perspective of anaesthetists in training is to champion the issues that keep you safe and supported in the workplace. Anaesthesia is a fascinating but hard job, and it is ETE's role to try and help you progress in your careers, so to that end please feel free to contact me on sthornton@rcoa.ac.uk or on Twitter @drmumsjt.

Dr Jon Chambers

Bernard Johnson Advisor for Training

I am a consultant anaesthetist in Dorset, having trained in Cornwall, Wessex and Michigan. I have been College tutor, guardian of safe working and regional advisor in the Wessex region, and I am privileged to have been appointed as the first Bernard Johnson Advisor (BJA) for Training at the College. The BJA for Training is a new role developed at the request of the Anaesthetists in Training Committee. In this role I am here to support and guide all those who are currently in an anaesthetics training post, or who are using alternative training routes in order to achieve a CCT or CESR. In addition, I am available to those with a role in supporting training, such as regional advisors, College tutors, clinical directors and training programme directors, to coordinate the exchange of expertise in matters relating to training and career development in anaesthesia. The landscape of clinical practice and training has been significantly affected by the events of the last few years. Alongside the brilliant support provided within each of the schools of anaesthesia, I will continue to act as an independent voice to raise and address the issues impacting on anaesthetic training both inside and outside the College.

You can contact me via email on jchambers@rcoa.ac.uk.

Dr Rashmi Rebello

Elected Council member; Co-chair of the Anaesthetists in Training Committee

I am Dr Rashmi Rebello, an ST6 anaesthetics registrar currently based at Oxford University Hospitals. I co-chair the Anaesthetist in Training Committee, which consists of highly motivated trainee representatives coming together to discuss trainee issues regarding various aspects of College work such as exams, training, recruitment, etc. This group has played an active role in enabling two-way communication between trainees and the College, and I am very glad to be part of it.

I also sit on the Academy of Medical Royal Colleges trainee group, which consists of trainee representatives from these colleges. Together we share our experiences, both good and bad, and take back learning points to our respective colleges.

Being a trainee myself has exposed me to both the highs and lows of training, while being on Council has given me insight into the amount of work that goes on behind the scenes. We have been strongly supported by our president, members of Council and the executive team throughout. The journey can get tough at times, but your trainee reps are here to make sure your voices are heard and accurately represented.

You can contact your team of trainee representatives via email to trainee@rcoa.ac.uk.

Emily Worth
RCoA Head of Membership Engagement
engage@rcoa.ac.uk

Get to know the team: Membership Engagement

Let me introduce myself, I'm Head of Membership Engagement at the College, and this May will be my fifth anniversary. Over these five years the College has changed, with an increased focus on engaging with our members, so it's a good time to highlight the work of my team and some top tips to get the most from your membership.

Who are the Membership Engagement team?

We're a team of six, with three key areas of responsibility: engagement, operations and the College's contact database system.

If you contact the Membership Engagement team via email, phone or send a request through *My RCoA* (the members' portal), you're likely to have correspondence with Laura, Ewelina, Jess or Naadine. You're also likely to meet us at events such as the online *Let's Talk* sessions or the face-to-face flagship events, *Anaesthesia* and *Winter Symposium*.

Managing and developing our contact database is Chris and Zsombor. This system is essential to the College as it holds all our membership information. It enables *My RCoA* to verify members, providing them access to their accounts and the journals included in their subscription. It also links to the Lifelong Learning Platform, and we're developing how it links to our event and exam registration system.

We work closely with many of the other teams to ensure we answer your membership queries quickly, but in particular: finance, training, examinations, digital, events and marketing and communications.

What is the remit of the Membership Engagement team?

Our main aim is to provide you with excellent service. We're often the first point of contact and can assist with most queries, but if we're unable to help, we forward the query to the relevant team within the College for their review and action.

We have the responsibility of ensuring prospective and existing members join/ have the correct membership category, receive their associated benefits, and know about the services the College offers. We continue to review what our members value about their membership. This helps to identify if changes are required, whether that be benefits to members, promoting the work of the College or improving/ introducing new services.

Within our remit is managing the College's membership payment processes, which is our main source of income. Working with the Finance team, we aim to communicate the details of upcoming membership payment(s), process any change requests, and organise payment by direct debit instructions or card payments via *My RCoA*.

Why do you think anaesthetists in training are important to the College?

Anaesthetists in training are an active group within our membership and provide us with their valuable time to inform us on a wide range of topics, from workforce challenges to modernising our technology. They are always one of the most responsive groups when we send out surveys or requests to get involved with the work of the College. Insights and ideas from anaesthetists in training have helped shape the future focus of the College, ensuring we're inclusive, sustainable, and innovative.

Anaesthetists in training are the future of the College, as well as the specialty, so their support now, but also beyond training, is key to enabling us to fulfil our strategic aims; championing our membership, shaping the future of our specialties, pursuing excellence in everything we do, and promoting healthier outcomes for all.

What would be your team's top tips for anaesthetists in training, so they get the most out of all the benefits offered by the College?

- Stay up to date. Keep an eye on our website and newsletters; *President's News*, and *The Gas*.
- Make connections. College tutors, regional advisors, anaesthetists in training representatives on Council, including the co-opted representatives, plus representatives that sit on the Anaesthetists in Training Representative Group (ATRG), are all there to support you and be your voice at the College. I would also encourage you to join the *Let's Talk* sessions to discuss hot topics with College leaders.
- Know your College teams and how they can assist you. The Training team will be your main port of call as they provide a wide range of services for trainees, including managing the Lifelong Learning Platform. The Examination team will support you through the examination process. They, along with the Events and Training teams, provide resources to assist you in your revision and learning. The Membership Engagement team are here to support you with any query about your membership, fees, and benefits.
- Activate your *My RCoA* account at myrcoa.rcoa.ac.uk, if you have not done so already, as it will make it far easier for you to update your details, choose your preferences and access our publications.

If you have any feedback for the College, please send us an email at engage@rcoa.ac.uk, and we will share with colleagues.

Useful contacts

Membership Engagement | 020 7092 1700 | membership@rcoa.ac.uk
Training | 020 7092 1550 | training@rcoa.ac.uk
Examinations | 020 7092 1520 | exams@rcoa.ac.uk

Steven Cutler
RCoA Assessment and Quality Data Manager
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Lifelong Learning Platform – continuing to evolve

Since its launch in August 2018, the Lifelong Learning Platform (LLP) has undergone an unprecedented amount of change. As well as adding the new Anaesthetic and ACCS 2021 curricula in August 2021, it also supports CPD Learners for Revalidation and FICM users, and automatically updates member details via our Customer Relationship Management system.

The platform continues to receive extremely high levels of use, supporting the career lifecycle of more than 24,000 fellows and members in the UK. Currently more than 21,000 of these have used the LLP for assessments and documenting their training in general. In a typical month there will be more than 400,000 LLP user interactions, including 100,000 Logbook entries and the addition of 45,000 Workplace Based Assessments or Supervised Learning Events.

Listening to trainees

The platform is continuing to evolve, but the LLP support team needs your feedback on usability and your suggestions for improvements to maintain a product that is fit for purpose. A recent user-survey has helped us identify some underlying issues, and highlighted where some functionality needs changing. The survey also helped us identify what our users like about the platform, and the highest scoring themes are listed below:

- a fully integrated platform that includes Logbook functionality
- the user interface and general layout
- the approvals process and most workflows
- the way the platform can be fully customised
- works well across most device types (mobile phones).

The current Logbook was one area that was identified as lacking in some regards, and we have been working with trainee representatives, and other stakeholders, to agree what will be included in the new version. Work to deliver this is already under way. We will be running additional user-surveys to obtain your feedback after delivering any significant changes to the platform.

Dealing with your enquiries

The LLP support team receives and responds to many enquiries every day (more than 18,000 during 2022). Your emails to lifelong@rcoa.ac.uk and llp@ficm.ac.uk automatically open tickets within our Helpdesk system, which our small but dedicated team then categorise, prioritise, and proceed to work on. In most cases issues can be directly and quickly resolved by the team, but any system bugs identified must be logged with our external developers for investigation and resolution. This can lead to longer delays in a few cases, but we work closely with the developers to ensure that our tickets are prioritised correctly, focusing on security, stability, and the number of users affected by any bug reported.

Increased support budget and new projects

Towards the end of last year, the College agreed to significantly increase the budget allocated to the LLP. This has already allowed us to reduce the backlog of tickets we have with our external developers and to start planning several special projects and initiatives.

We have provided a list of some of these projects below, and have already successfully delivered a major security and stability update (Laravel) to the platform's web-hosting system. This update had to be implemented before any other significant projects or general improvements could start, so we are very happy to report that this was delivered within budget and without any issues at the end of January.

The London deaneries were also recently merged in a project fully funded by Health Education England. This has provided a significant improvement for users within this deanery, particularly those involved with organising ARCPs.

Other key proposed improvement projects are listed below, most of which are related to the security, stability, reliability, maintenance, and ease of delivering future developments:

- improved user-data storage, retrieval and archiving
- stronger authentication
- automated regression-testing
- improved business-logic
- end-user documentation and online help.

Recent improvements and changes

We post a list of recent changes to the platform on the following web page, and recommend that users visit this regularly to check if something has been improved or an issue has been resolved: rcoa.ac.uk/training-careers/lifelong-learning/guidance-material

LLP Regional Leads

We would like to thank everyone who recently volunteered for this important role. We are still in the process of adding the contact details for some regional leads, and will continue to update the list found on the following web page: rcoa.ac.uk/training-careers/lifelong-learning/support-contacts

Your regional lead has the following responsibilities, and may be able to help you with any questions or issues have when using the LLP:

- act as initial point of contact within your region for enquiries from ACCS, Anaesthetics, and ICM users of the LLP. Where appropriate the role(s) may be jointly shared to provide guidance for various types of users
- provide 'hands-on' guidance and support as appropriate to users of the LLP within their region
- work with the LLP Team to report on and review common queries and improvement requests from users within their region
- join periodic 'virtual' update meetings with the LLP Team, and to report back to their region on the key messages and communications from these.

Access the Lifelong Learning Platform at:
lifelong.rcoa.ac.uk

Dr Sonia Pierce
Consultant in Pain Medicine,
FPM Regional Advisor in Pain Medicine, Wales
contact@fpm.ac.uk

Faculty of Pain Medicine (FPM)

FPMLearning

FPMLearning is the learning platform for the Faculty of Pain Medicine and is an open resource for all doctors working or training in pain medicine. It provides access to a variety of educational materials to support training and continued professional development.

The platform which can be accessed at fpm.ac.uk/fpmlearning brings together a range of resources, including clinical case reports, recommended reading material, webinars, podcasts and updated exam resources. FPMLearning provides links to high-quality external learning materials, as well as signposting to relevant educational resources from within the FPM itself.

A new case report is published monthly, and the series aims to cover a variety of topics relevant to a range of pain-medicine clinical practice. These interesting cases aim to generate discussion, and the readers are posed with questions to encourage thinking. There are monthly recommended reading resources relevant to the topic presented in the clinical cases, which cover a variety of multidisciplinary aspects of pain medicine. We hope that some of the suggestions may inspire the reader to discover something new across the broad field of pain medicine.

There are several developments on the horizon, including a 'Radiology in Pain Medicine Corner' and a section on relevant national pain-guidelines, which will be launched soon. We hope to add content relating to interventional pain medicine in the near future. In addition, we are looking to improve the accessibility and searchability of the content on FPMLearning, with improved archiving capabilities for ease of access to the expanding educational material available.

We have a growing list of contributors who write the monthly case reports, and we have recently launched a case competition, open to all those working in or with an interest in pain medicine. The judges will consider relevance, originality, interest, and quality of writing. If you have any suggestions to help us further develop the platform, or if you wish to contribute in any way, please contact us at contact@fpm.ac.uk.

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Dr Chris Thorpe
FICM Training, Assessment and Quality Committee
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TRAINING AND THE GMC

Delivering training is a complex process. One of the disconnects that crops up between the FICM and intensivists in training is fuelled by the constraints of how the curriculum is delivered. While there are aspects of training that we can adjust, we are very much constrained by the GMC, which is our statutory body for training.

All changes need to be approved by them – and this includes everything from exam delivery to developing new special-skills years. The GMC had their hands full with developing the new curricula across all specialties, and asked that no further adjustments were made until the new curriculum is bedded in.

For anaesthetists following a dual training pathway, the special-skills year is within the anaesthetics arm of the programme, so there is no opportunity for undertaking special-skills year in an ICM-related attachment. This means that those dual trainees wanting to undertake pre-hospital emergency medicine, for example, would have to take an extra year.

This also affects trainees wanting to undertake a career in cardiothoracic anaesthesia and intensive care medicine. The need to train in echocardiography to a high level adds extra time onto the dual-CCT.

The change in curriculum to primarily outcomes-based assessment does allow some flexibility, and hopefully as we bed in we can look at whether there is potential to streamline the training more effectively.

Although some of this is within our remit to assess, we would need to work with the GMC to get any proposals approved. Reducing unnecessary training burden is so important that we need to consider potential changes carefully, and the GMC provides an important backstop to ensure that the curriculum continues to produce safe, competent consultants.

Dr Sunil Kumar
RCoA SAS Council Member
sas@rcoa.ac.uk

SAS Doctors

SPOTLIGHTING THE ACHIEVEMENTS OF SAS DOCTORS

More than one in five of the non-trainee anaesthetic workforce are SAS doctors, yet the grade is still sometimes misunderstood.

The College is keen for SAS doctors to get the recognition and support they deserve. As SAS Wellbeing lead, I started an initiative last year to spotlight the achievements of our SAS members by asking them to share their stories with us for publication on the College website and social media. Our aim was to enhance people's understanding of the huge range of skills, experience and responsibilities of SAS doctors, to boost pride in being an SAS doctor, and to improve wellbeing.

We had a very positive response to the initiative. The profiles we collected illustrated the many different roles and responsibilities of SAS doctors, as well as providing insights into the benefits, for example through enabling a better work–life balance. All contributions are still available on our website and I share a couple of them here.

Dr Mark Clayton

Specialty Doctor in Anaesthesia and Critical Care, Northern Lincolnshire and Goole NHS Foundation Trust

I'm Mark and I've been an SAS doctor at a district general hospital since 2017, having left training due to physical health issues. I like the variety of challenges that working in theatre, critical care and obstetric anaesthesia provide, and I'm fortunate to work in a department that values the experience of its SAS team.

Over the last year a number of us have been given leadership roles, and I have taken on the department lead role for emergency anaesthesia and resuscitation, reflecting my experience as an advanced life support medical director and european paediatric life support instructor as well as my long-term experience as a pre-hospital clinician.

SAS doctors within my department take an active role in the training of medical students, foundation doctors and specialty trainees, and I took the lead in designing our induction programme as well as delivering the face-to-face critical care sessions. I was also fortunate enough to be chosen to attend advanced ventilator training alongside several of our critical care consultants in order to become one of the department's 'clinical experts'.

Outside of the hospital, I am employed by East Anglian Air Ambulance as an emeritus fellow in pre-hospital emergency medicine and regularly undertake helicopter emergency medical service shifts where my anaesthetic and critical care skills are in daily use. I also volunteer extensively with a number of organisations, including St John Ambulance where I am an event-doctor as well as district clinical officer, and LIVES (my local British Association for Immediate Care charity) where I work as a medical first responder and critical care team member. As an SAS anaesthetist, I am afforded the trust to undertake advanced clinical procedures, including pre-hospital anaesthetic and sedation, for both of these organisations.

Away from anaesthesia, I am employed as one of the regional medical examiners and have found that my experiences reviewing patients as part of critical care referrals has meant that I can rapidly review a set of notes and draw sensible conclusions. I am an SAS doctor by choice, and the flexibility given by my role allows me to enjoy a portfolio career as well as maintain a work–life balance that keeps me happy during these difficult times.

Dr Prajwal Shetty

SAS Doctor
Cumberland Infirmary Carlisle

I have been an anaesthetist since 2013, and I love my job. Being an SAS doctor gives me the liberty to use my expertise and skills to bring smiles to my patients' faces.

The recognition I get from my patients, colleagues, and from staff keeps me going and striving for the best. A patient recently asked me if she could give a five-star rating on Trustpilot for my anaesthetic and operating-room team. How can I not be motivated after this?

I am most proud of my department. There is a sense of camaraderie between every member of the staff in our small but highly skilful team. Despite being an SAS doctor, I have been encouraged in my academic activities, research, presentations, and teaching of trainees. My department has always supported me through thick and thin. I am proud to be associated with the department of anaesthetists and intensivists at the Cumberland Infirmary, Carlisle.

I was trained in India, and I am still associated with academic activities at my alma mater. Beyond my role, I have been involved in teaching activities for postgraduates and as a presenter in online and face-to-face CMEs. It is my humble aim to spread and improve the quality of anaesthesia practice to the young budding anaesthetists.

Being an SAS doctor helped me gain the competencies specified by the curriculum and made me eligible for ST4 training. My College tutors at the trust were an immense help in guiding me through, and all my consultants helped me practise the interview and exam process. Currently, I am an ST4 trainee at the East Midlands Deanery, and whatever I achieve will be due to the support and experience I gained throughout my job.

Find out more about how the College supports SAS doctors and how you can get involved at rcoa.ac.uk/sas

This initiative is ongoing, so if you'd like to share your experience of being an SAS doctor do email **comms@rcoa.ac.uk**.

Revalidation for anaesthetists

GUIDANCE ON PERSONAL DEVELOPMENT PLANS

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We would like to use this *Bulletin* article to focus on setting up a Personal Development Plan (PDP), some guidance on what should and should not get included, and to address a query about using your PDP in the Lifelong Learning Platform. In providing this advice we are making reference to the Mythbusters[1] guidance which has been produced by the Academy of Medical Royal Colleges.

The goals within the PDP should be taken from your appraisal, and should meet your needs and the context within which you work. It is recommended that goals are developed with your appraiser using SMART (Specific, Measurable, Achievable, Relevant and Timely) objectives, and it often helps to work out how you can demonstrate that a change planned as one of your goals has made a difference, by considering its impact on patients.

Your PDP goals should be balanced across the five-year revalidation cycle and across your whole scope of work, although it is not appropriate to include ones which are irrelevant to your specific needs or which could apply to any doctor for them to be fit to practise.

While the GMC requires you to make progress with your PDP each year or to explain why this has not been possible, it does not mandate what your PDP should include, nor is there a requirement about how many goals should be featured or if these should be clinical or non-clinical. Most doctors find three or four PDP items are sufficient to capture their priority goals. Ultimately the content of the PDP is a matter for agreement between you and your appraiser. Performance objectives should be part of job planning and not necessarily part of your appraisal and revalidation PDP unless you wish to include them.

Focusing on the Lifelong Learning Platform, we periodically receive enquiries where a learner cannot mark their PDP as complete. The usual reason for this is that the PDP will have been created by their supervisor, and will need to be addressed in this way.

We have also received requests that guidance should get produced on the different pathways for anaesthetists in training and for non-trainees, again with a focus on the Lifelong Learning Platform. We will be starting work on this guidance soon, so please contact cpd@rcoa.ac.uk if there are any particular areas which you would like this to focus on.

Reference

1 Mythbusters: Appraisal and revalidation, *AoMRC*, 2018. (bit.ly/2oInpZx).

PERIOPERATIVE JOURNAL WATCH

Dr Olivia Coombs, ST5, North West Deanery

Perioperative Journal Watch is written by TRIPOM (trainees with an interest in perioperative medicine – tripom.org) and is a brief distillation of recent important papers and articles on perioperative medicine from across the spectrum of medical publications.

A randomised controlled trial in patients undergoing arthroscopic shoulder surgery comparing interscalene block with either 10ml or 20ml levobupivacaine 0.25%

This single-centre study investigated the difference in diaphragmatic function of 48 patients receiving either 10 or 20ml of 0.25% levobupivacaine in an ultrasound-guided interscalene block prior to shoulder surgery.

The primary outcome was the ratio of inspired to expired hemidiaphragmatic thickness; a ratio of <1.2 represented decreased function. 4/24 participants receiving 10ml vs 23/24 receiving 20ml had decreased diaphragmatic function based on this ratio while sitting ($p<0.001$), with similar results; 6/24 vs 23/24 for 10ml and 20ml respectively when measured in the supine position ($p<0.001$). There was no significant difference in postoperative spirometry changes between the groups, but there were more complications noted with 20ml compared to 10ml (7/24 vs 0/24; $p=0.0009$).

Oliver-Fornies P *et al*. *Anaesthesia* 2022; **77(10)**:1106-1112 doi.org/10.1111/anae.15822.

Rescue treatment of postoperative nausea and vomiting: a systematic review of current clinical evidence

Much research has investigated the efficacy of prophylaxis for postoperative nausea and vomiting (PONV), with comparatively few studies focusing on rescue treatments. This systematic review included 46 papers and used a descriptive synthesis to summarise the evidence for PONV rescue. Due to a lack of overlap between studies, a quantitative meta-analysis was not performed.

The main conclusions included: 4mg of ondansetron was effective for PONV rescue, but redosing with any 5-HT3 antagonist after failed ondansetron prophylaxis was ineffectual; metoclopramide is less effective than other anti-emetics; and multimodal management is better than single drug treatment. However, the preferable first-line drug option could not be assessed due to lack of comparison studies. A useful infographic and algorithm were created to summarise the findings.

Gan TJ *et al*. *Anesthesia & Analgesia* 2022; **135(5)**:986-1000 doi.org/10.1213/ane.0000000000006126.

Pre-operative fasting in children: a guideline from the European Society of Anaesthesiology and Intensive Care

This guideline was published following a large-scale systematic review. The article summarises the evidence, and subsequent discussion among the expert panel, culminating in 7 recommendations and 19 suggestions with regards to paediatric perioperative fasting.

The main conclusion was to recommend a 6-3-1 hour/s fasting regime for solids, breastmilk, and clear fluids respectively with 1B and 1C Grade of evidence. Other suggestions, such as allowing a light breakfast or non-human milk up to four hours prior to surgery, did not reach consensus among the expert panel and were suggested as Grade 2 evidence, highlighting that there is still some concern regarding the risk of aspiration and possible lung injury, with a lack of strong evidence to recommend less than six hours fasting for solids and non-clear fluids.

Frykholm P *et al*. *European Journal of Anaesthesiology* 2022; **39(1)**:4-25 doi.org/10.1097/eja.0000000000001599.

Virtual reality in paediatrics, effects on pain and anxiety: a systematic review and meta-analysis update

Advances in technology mean virtual reality (VR) equipment is now more feasible as a tool to combat pain and anxiety during procedures in children. This meta-analysis included 27 studies to explore the potential benefits of immersive VR as a distraction technique or as a pre-procedure method of exposure, to prepare patients for what to expect.

When considering VR distraction compared with usual care, the standardised mean difference (SMD) was -0.67 (95%CI -0.89 to -0.45; $p<0.001$) for patient-reported pain scores and -0.74 (95%CI -1.00 to -0.48; $p<0.001$) for patient-reported anxiety. Statistically significant differences were also noted with parent-reported pain and anxiety scores.

Four papers were analysed in relation to VR as an exposure tool. VR significantly improved patient-reported anxiety (SMD = -0.58; 95%CI -1.15 to -0.01; $p<0.05$) versus usual care.

Tas FQ *et al*. *Pediatric Anesthesia* 2022; **32(12)**:1292-1304

doi.org/10.1111/pan.14546.

PatientsVoices@RCoA

THREE DOGS, A CAT AND A PLAN!

Pauline Elliott
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I doubt there are many *Bulletin* readers who are old enough to remember the 1963 Disney film 'The Incredible Journey'. Luath – a golden labrador, Bodger – an aging bull terrier, and Tao – a Siamese cat make a perilous journey across the Canadian wilderness to get to their home 300 miles away. As a little girl I sat in the Ritz Cinema with tears flowing because it seemed inevitable that Bodger had died in the final few miles of the journey. Of course he hadn't. He trotted over the horizon to an ecstatic welcome from his animal and human family.

I was reminded of Bodger and his fictional achievement when I read about a dog called Pip. Last year Pip's owner took him for a run in Leigh Woods, a beauty spot in Bristol. They became separated, and Pip's frantic owner took to social media to get help finding him. Pip was soon spotted on the city's security cameras. He crossed Brunel's iconic suspension bridge, ran past the famous BBC studios in Whiteladies Road and was captured on camera running by the steps of the museum. Somehow he safely negotiated the notoriously dangerous traffic in the city centre and found his way to his front garden in Bedminster – about four miles from where he'd left his owner. In fact he got home before she did!

Luath, Bodger, Tao and Pip were pretty single-minded. Their mission was to get from A to B – from where they were to where they wanted to be. We mere humans usually lack such focused determination, and we certainly don't have those innate instincts and abilities which somehow ensure animals and birds get where they want to go. We need help to achieve our goals. We need a plan.

The College's five-year commitment recognises the vital role of patient and public involvement in ensuring it meets its ambitious aims. Over the past year we've worked with the College to refresh the Lay Committee, creating a new name and image as PatientsVoices@RCoA. We're committed to helping the College achieve its aims by ensuring the patient voice is heard loudly and clearly throughout the organisation.

However, to achieve our objectives we need more than a new name and logo. We need a map which guides us on our journey from a traditional royal college lay committee to a modern, dynamic group which seeks out and embraces diversity in its membership and its ways of working.

Our strategic plan (rcoa.ac.uk/patientsvoicesrcoa-strategy) is that map.

Our plan demonstrates how we've aligned our vision, values and aims with those of the College. PatientsVoices@RCoA share the College values which

underpin our aspirations for change and improvement. We're committed to being caring and supportive, just and fair, innovative and progressive, and open and responsive. Our plan explains in detail what those values mean to us as patients' voices.

Working as a team with the invaluable support of Sharon Drake, Carly Melbourne and El Fabbrani, PatientsVoices@RCoA developed our three strategic pillars. These set out our key priorities for the next five years (where we want to get to) and the actions we're going to take to achieve our aims (how we're going to get there).

We're going to focus on developing a stronger, more influential, and more representative voice. That will involve establishing ourselves as the voice of diverse patients and communities and encouraging the College and its members to work with us and seek our contribution. We know we'll need to develop ourselves to show that we can contribute authoritatively and effectively.

We aim to improve how we communicate and engage internally and externally. To achieve this we plan to raise our profile and promote meaningful patient engagement by working with stakeholders in a constructive and supportive way.

We also aim to increase our impact by developing effective ways of working. We'll do this by maturing as a team and working out a variety of approaches to ensure patients' voices positively impact on College activities and recommendations about patient care.

PatientsVoices@RCoA have already made some progress on our journey. We're a diverse group of people from different communities. But we can and must do more to ensure we represent a broader range of patients' and the public's views and priorities. We're making our voice heard in the College, for example at Town Hall meetings, and in the wider anaesthetic community. We were on the stage at Anaesthesia 2022 and we'll be there again at Anaesthesia 2023. We're trying out new, more impactful ways of working, such as our recent focus group on anaesthesia associates.

Luath, Bodger, Tao and Pip showed courage and determination to get from where they were to where they wanted to be. PatientsVoices@RCoA are likewise courageous and determined. And we have a plan!

Patients Voices @RCoA

Find out more about **PatientsVoices@RCoA** and the work we do on our website: rcoa.ac.uk/patient-public-involvement

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Dr Sian Jaggar
RCoA AAC Lead

Becoming an AAC assessor

You may well ask why you should think of becoming an AAC (advisory appointments committee) assessor. Perhaps it will be too arduous/boring/difficult. We hope to persuade you that this is not the case, and further explain what it can do for you and your department.

When your department appoints a new consultant or specialist doctor, there are specific requirements that must be fulfilled. One of the most important of these is to hold an AAC. This is a legally constituted interview panel established by an employing body. Its function is to decide which, if any, of the applicants is suitable for appointment and to make a recommendation to the employing body.

All NHS trusts/boards are required by the consultant appointment regulations,[1] produced by the Department of Health (DH), to include a representative from the appropriate medical college or faculty on the appointment committee. NHS foundation trusts are not required by law to follow these regulations; however they are strongly encouraged by the Academy of Medical Royal Colleges and the Foundation Trust Network to do so.[2] The process to secure a representative of the RCoA, FICM or FPM is the same for all trusts, regardless of their foundation status.

The college assessor is the only statutory external influence on an AAC. Along with the other committee members, the assessor must ensure that the best candidate for the job is appointed. Furthermore, they are required to confirm that the process is fair and open within current legislation, and current employment practice. What does this all mean in practice?

Firstly, any external assessor has to be nominated by the relevant college through its AAC department. Each college has a pool of people who agree to attend these committees, and we hope you might wish to become one of these for RCoA.

The external assessor should take part in the shortlisting, and must certainly have seen the application forms of all candidates who will be attending it ahead of the AAC. On the day of appointment, the principal role of the external representative on the committee is to assess the suitability of the candidate through their application form against the person specification in the job description written by the trust. The trust will also expect the college representative to confirm that candidates are suitably trained in the specialty. However, he/she also has an equal role to all other panel members when discussing the candidates. Indeed, many non-anaesthetic panel members particularly value this independent assessment of candidate suitability, because it provides external benchmarking and validation of the panel. The assessor helps to ensure that standards are not relaxed consequent upon challenges with local service provision, allowing quality of services and patient safety to be maintained.

For purposes of impartiality, an assessor should be from outside the region where the appointment is taking place. Since the pandemic, many AACs have become virtual. This means that travelling to these interviews is no longer the problem it once was. If you do need to travel, expenses, along with the nominal fee, are provided. We need the pool of RCoA assessors to increase; currently we cannot always guarantee an external assessor for every AAC.

Although the role of an external assessor carries significant responsibility, there are many anaesthetists who will have the necessary experience and expertise. You would need to:

- review the criteria for application[3]
- apply via the form on the RCoA website[3]
- state which areas of specialism you would be happy to assess for – you will not be asked to undertake panels you feel you are unsuitable for
- undertake basic online training provided (not a great time commitment) through the Royal College of Physicians, to support you in the work
- attend one of the annual face-to-face training sessions at RCoA at least once every three years
- attend a minimum of two AACs every year – from which you should provide feedback for the RCoA.

There is also further guidance for external assessors on the RCoA website.[4] If you are, or have been, a clinical lead, clinical director, College tutor, or have or have had significant roles in local consultant or trainee recruitment or training, you would be eligible.

The post should not become an arduous commitment for any successful applicants. In reality, it is an interesting role. External assessors gain an insight into the workings of other departments, the quality of candidates that are available outside their own region, and further experience in improving their own recruitment processes. Thus, the work itself is an effective use of SPA time, providing relevant CPD. Training days are another good time to network with colleagues from around the country, bringing new ideas back to your own department.

The DH is clear that it wishes trusts to allow consultants to undertake work important for the wider NHS[5] and this is an important such role. It may also help your department to repay the time given to it by externals for their own recruitment processes. We would strongly encourage you to apply.

References

1 The National Health Service (Appointment of Consultants) Regulations [Archived content] (bit.ly/3Zj94ST).

2 Condordat between Medical Royal Colleges, *Academy of Medical Royal Colleges,* 2010. (bit.ly/3Ke8dyp).

3 Advisory Appointment Committee (AAC) Assessor Application Form, RCoA (rcoa.ac.uk/form/advisory-appointment-committee-aac-assessor).

4 Guidance for College representatives on AACs (rcoa.ac.uk/guidance-college-reps-AACs).

5 Joint letter from Department of Health, Academy of Royal Colleges, General Medical Council and NHS (bit.ly/3Ib43Vs).

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National Emergency Laparotomy Audit (NELA)

NELA INTO THE SECOND DECADE

The National Emergency Laparotomy Audit (NELA) has been a real success story – engaging with clinical teams and feeding back high-quality comparative process and outcomes data to improve care.[1,2,3] As NELA enters its second decade, it is important to look at persisting challenges as well as successes, and consider where improvement efforts should now be concentrated. This article highlights three areas of emphasis from Year 10 (2023) of the audit.

Infection and sepsis management

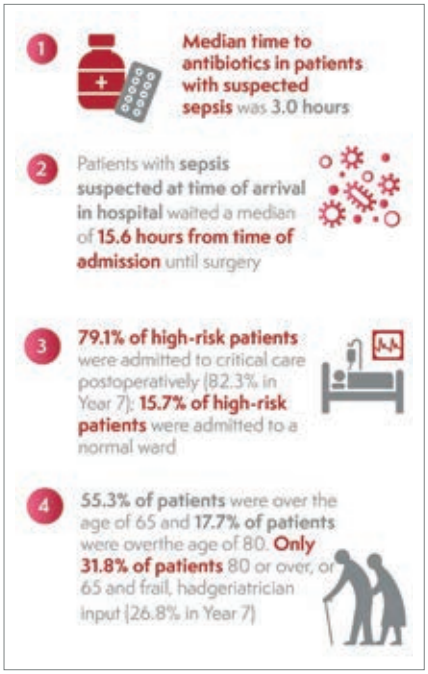
Successive NELA reports have highlighted failings in this area – with many patients recorded as having sepsis at admission and/or at time of the decision to operate (DTO), but seemingly poor timeliness of care in terms of both antibiotic administration and definitive source control. Closer examination reveals potentially missed opportunities to streamline decision-making 'upstream' of the DTO. Year 8 data[3] shows that the median time from arrival in hospital to arrival in theatre for those with sepsis at time of arrival was 15.6 hours. Fewer than a quarter of those with sepsis on arrival at hospital received antibiotics within an hour. This finding might be partially explained by an over-interpretation of the term 'sepsis'. NELA has attempted to unpick this during Year 9 (2021–2023) by auditing those with 'infection' as well as 'sepsis' to better define the denominator.

The topic is timely, with recent guidance published by the Academy of Medical Royal Colleges in October 2022.[4] In non-surgical patients, there is now an emphasis on the balance between optimised antimicrobial prescribing and antibiotic stewardship, with some extra leeway on timeliness of antibiotic administration. But for surgical patients, targets remain as 1 hour for those with sepsis (NEWS2 5+), and state that surgery to control the source of sepsis should commence within 3–6 hours depending on the severity of sepsis. Clearly emergency departments are under extreme pressure in the current NHS climate, but NELA will continue to work in collaboration with emergency-medicine and surgical colleagues to improve the diagnostic and early infection-management pathways for patients.

Risk assessment

Risk assessment is a key step in ensuring processes of care meet the needs of the patient: appropriate standards are more likely to be delivered once it is recognised that a patient is at increased risk of complications following surgery. This high-risk group includes those with moderate frailty (Clinical Frailty Score [CFS] of 5 or greater).[5] To ensure better care and better outcomes for this group, NELA will, beginning in Year 10,

Year 8 NELA report– key messages



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Adapted with permission from HQIP 2023, Eighth Patient Report of the National Emergency Laparotomy Audit.

audit the number of patients aged over 65 with a documented assessment of frailty, and will add frailty (CFS of 5+) to the list of factors classifying the patient as being at high risk.

NELA has used several formal risk-assessment tools since it's work started in 2012. While P-POSSUM was initially used, NELA was able to develop a bespoke and specific scoring tool ('NELA risk') using fewer variables to give a score that more accurately predicted mortality risk.[6] NELA have completed work to develop a further iteration – using just 13 variables and, importantly, for the first time taking into account predicted surgical pathology. We hope to have this 'parsimonious risk score' built into NELA risk calculators by April.

Year 8 NELA report – length of hospital stay and mortality by geriatrician review[3]

	Geriatrician review		No geriatrician review	
	Length of postoperative hospital stay median [IQR]	In-hospital mortality	Length of postoperative hospital stay median [IQR]	In-hospital mortality
Aged ≥65 years and non-frail (n=6,460)	13 days [7–22 days] n=1,752	5.9%	9 days [6–15 days] n=3,598	9.5%
Aged ≥65 years and frail (n=4,130)	16 days [10–28 days] n=1,327	13.0%	11 days [8–21 days] n=2,028	22.3%
Aged 65–79 years and non-frail (n=4,931)	12 days [7–23 days] n=1,249	5.0%	9 days [6–15 days] n=2,849	8.2%
Aged 65–79 years and frail (n=2,253)	16 days [9–29 days] n=656	11.9%	11 days [6–20 days] n=1,171	21.9%
Aged ≥80 years and non-frail (n=1,529)	13 days [8–22.5 days] n=503	8.2%	10 days [6–17 days] n=749	14.6%
Aged ≥80 years and frail (n=1,877)	16 days [10–27 days] n=671	14.2%	11 days [6–19 days] n=857	23.1%

Perioperative medicine and best-practice tariff (BPT)

The Centre for Perioperative Care (CPOC) guidance for frail and elderly patients[5] includes a standard that hospitals should 'have a perioperative frailty team with expertise in comprehensive geriatric assessment (CGA) providing clinical care throughout the pathway'. This team should be able to deliver (among other goals) assessment and management of postoperative medical complications, hospital-acquired deconditioning and postoperative cognitive disorders, and be involved in rehabilitation and discharge planning. NHS England (NHSE) are likely to make a change to existing BPT arrangements, financially incentivising involvement of perioperative medical teams (using the above definition) for elderly and frail patients once stepped down to a surgical ward (and moving away from the current BPT emphasis around standards of care for high-risk patients).

Beyond Year 10

In Years 11 and 12, NELA will work to include an additional workstream to audit standards of care for those who in some circumstances would have undergone a laparotomy, but who for a number of reasons do not (the so-called 'NoLap' group.) A phased approach to inclusion of this group may be explored as we develop both methodology and an appropriate audit dataset.

Summary

While care standards for emergency laparotomy patients have improved significantly, the work of NELA remains as important as ever, with an evolving emphasis into wider aspects of the patient journey.

Year 10 of the audit will bring a more efficient risk-assessment tool, an emphasis on decision-making and early management for those with infection and sepsis, and will, via the NHSE BPT scheme, probably see financial incentives to improve the ability of hospitals to provide enhanced levels of multidisciplinary care for vulnerable, elderly and frail emergency laparotomy patients.

References

1 Murray D. HSRC Annual Report: a decade of NELA. RCoA *Bulletin* 2022; **134**:32-33.

2 Seventh Patient Report of the National Emergency Laparotomy Audit. RCoA, 2021. (nela.org.uk/Seventh-Patient-Report).

3 Eighth Patient Report of the National Emergency Laparotomy Audit. *RCoA*, 2023. (nela.org.uk/Eighth-Patient-Report).

4 Bion J *et al*. Academy of Medical Royal Colleges statement on the initial antimicrobial treatment of sepsis. *Academy of Medical Royal Colleges* 2022.

5 Guideline for perioperative care for people living with frailty undergoing elective and emergency surgery. *British Geriatrics Society and Centre for Perioperative Care*; September 2021. (bit.ly/3KeMer6).

6 Eugene N *et al*. Development and internal validation of a novel risk adjustment model for adult patients undergoing emergency laparotomy surgery: the National Emergency Laparotomy Audit risk model. *Br J Anaesth* 2018; **121**:739-748.

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AS WE WERE

A small boy in Arusha, Tanganyika and 'Aethernarkosen': Curt Theodore Schimmelbusch

1860–1895

Anaesthetists are familiar with the '*Schimmlebusch Mask*'. This article evolves from Arusha, Tanganyika and a small boy's memory of a white mask descending over his face circa 1963, having fallen while climbing the household log heap and splitting his eyebrow open, requiring sutures by the local doctor.

Open-ether-mask anaesthesia was a common and safe technique utilised in many countries at the time. Tadeusz Szreter's recollections of performing ether anaesthesia for children in the late 1950s in Poland is an illuminating read. He describes how two facemasks had to be prepared for each procedure, and how when one became covered in frost, it was replaced by the other. Each mask had to be covered with several layers of gauze neatly trimmed to prevent cheek frostbite. With regard to the safety of ether, Perndt in 2010 and Chang *et al* in 2015 wrote papers advocating a rethink of this abandoned agent.[1,2,3]

Numerous articles have been written about Curt Theodor Schimmelbusch (1860–1895) and his eponymous mask; this article is not attempting to review them all, the intention is to stimulate colleagues to explore for themselves.

Schimmelbusch is not generally recognised as a pioneer in anaesthesia; his historiographical importance is primarily for his pioneering publications in surgery. He was born in West Prussia and studied medicine at Wurzburg, Gottingen and Berlin before obtaining his medical degree in Halle in 1886 as a pupil of the histologist Eberth, carrying out a study of the role of platelets in the development of thrombosis and coming to the conclusion that the process of platelets latching onto the wall of the damaged vessel produced a plug in the circulation (College examiners should perhaps read this classic work). His surgical training continued in 1888 at Cologne under Bardenhauer, who had introduced 'Listerian Antisepsis' in 1875. In 1889, he returned to Berlin as assistant to Bergmann at the institute of the Zeigelstrasse. Bergmann was one of a generation of German surgeons adopting the principles of Koch's laboratory-based bacteriology and heat sterilisation. German surgeons had started distancing themselves from Lister's 'antisepsis' and were developing a strategy of 'asepsis'. Bergman is credited with modernising surgery at the institute and recruiting surgeons versed in experimental science. Schimmelbusch was one of those recruited, this resulted in 'asepsis' becoming a widespread new approach, and Schimmelbusch is credited as one of the inventors of the term 'asepsis'. In 1892, Schimmelbush published his authoritative work '*Anleitung zur aseptischan Wundbehandlung*' which was subsequently translated into many European languages. He devised a method of steam sterilisation that enabled instruments to be autoclaved within a container that could be transported to the operating theatre while maintaining sterility. Readers are strongly recommended to peruse Schimmelbusch's historically important treatise. Additionally in 1892 he described a cystadenomatous condition of the breast that became known as Schimmelbusch's disease.[4,5,6,7,8]

This brings us to the anaesthesia mask. A patent application describing the design was made in London on the 21 September 1889, predating the 1890 American patent application.[9], The mask features in *Dr G. Beck's Therapeutischer Almanach* of 1890 with the wonderfully precise title 'Maske und Maskenbestek

fur Chloroform und Aethernarkosen'. The practice of anaesthesia is also referred to in Schimmelbusch's treatise on sepsis with two pages dedicated to the topic, expressing his concerns for transmission of infections of erysipelas or diphtheria. He describes how his mask can be sterilised and the use of replaceable layers of cheap cloth, emphasising reducing the risks of transmission of infection associated with older chloroform apparatus such as Skinner's and Esmarch's masks which repeatedly reused the same covering cloth. One of the myths associated with Schimmlebusch's apparatus is that the grooved metal ring was designed to prevent liquid anaesthetic running on to the patient's face, whereas in fact the grooved ring is designed to assist in fixation of the cloth cover and cleaning.[5,8] Therefore Schimmelbusch's mask improved on previous versions, primarily reflecting his concerns about transmission of infection as part of the evolving German culture of *surgical asepsis* rather than evolving anaesthesia.

Schimmelbusch was one of the pioneers of his time and sadly succumbed to the 'white plague' of tuberculosis at the age of 35. His short obituary notice published in the *British Medical Journal* stated, 'He was recognised as one of the most distinguished of the younger generation of surgeons in Berlin and had already made a considerable reputation by his researches on thrombosis and the aseptic treatment of wounds', with no mention of his contribution to anaesthesia.

As for the young boy in Arusha, the fact he survived this early experience is a demonstration of the safety of facemask *aethernarkosen*. However, according to my late mother, the other children at the nursery helpfully commented when the stiches were due to be removed, that my eyeball would fall out. Apparently, I had to be pinned down and my screams could be heard across Tanganyika.

A collection of historic anaesthetic masks held at the College

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Please see the heritage and archive information on our website:

rcoa.ac.uk/heritage

LETTERS TO THE EDITOR

If you would like to submit a letter to the editor please email **bulletin@rcoa.ac.uk**

Dear Editor,

Why is this taking so long?!

We wish to highlight a patient-safety issue with regards to a newly introduced modification of the Ayre's T-piece.

Ayre's T-pieces are commonly used during paediatric anaesthesia. Our department recently introduced a new circuit – Meditech Breathing System Ayres T 1.6m, 10mm Eco Tube, with the valve incorporated inside the 15mm connector allowing direct swaps between the common gas outlet and piped oxygen.

Within the first few weeks following the introduction of the T-piece we had three episodes of failed gas inductions. All were due to the circuit being connected to the auxiliary oxygen outlet rather than the common gas outlet, likely due to the proximity of these on the Drager Zeus. On all occasions the oxygen had been left on with sufficient flows to give false reassurance of being able to pressurise the system.

In all cases no harm came to the children. The problem was quickly rectified, and they were successfully anaesthetised and discharged the same day.

This highlights a significant issue that occurred following introduction of a seemingly minor modification to a commonly used piece of equipment. Following this we have removed these circuits and resumed using our previous T-pieces.

This may represent a unique problem associated with the Zeus model from Drager, but we wish to highlight the importance of this new modification that has indeed solved one problem but potentially created another. While a failed gas induction is not ideal, it isn't dangerous. However there is potential for harm with an already anaesthetised child.

Dr Katie Wimble,
Anaesthetic ST7, Queen Victoria Hospital, East Grinstead.

Drs Colin Lawrence and Emma Glasgow,
Consultant Anaesthetists, Queen Victoria Hospital, East Grinstead

Dear Editor,

RCoA *Bulletin* 135, January 2023

We strongly support the article by Dr Summons: 'Integrating cultural competence into prehabilitation services'[1]

We run a prehabilitation clinic ('Me-Fit') at Medway NHS Foundation Trust and can relate to the challenges of cultural incompetence in managing patients within diverse ethnic groups. We serve a population where 15.7% of Medway consists of Black and Ethnic minorities.[2] The CQC Clinical Guidance[3] for culturally competent care needs and tailored services that respond to the patient's needs, preferences, and values emphasises nutrition as essential for healthcare planning.

During our search for culturally competent dietetics resources, we felt that the commonly used 'Eatwell Guide' by Public Health England[4] was a great pictorial resource, but focuses on western food options. These resources fail to engage alternative ethnicities that have different culinary choices. Recently, alternative Eatwell Guides for South Asian and Afro-Caribbean patients[5,6] have been developed. This enhanced resource, adapts the pictorial guide with culturally indigenous food. Webinars on 'MyNutriWeb' help with further information. We plan to incorporate these in our nutritional information leaflets.

In our experience, virtual or face-to-face exercise sessions catered to most of the cultural preferences. We also investigated provision of culture- and gender-sensitive facilities for exercise and came across the 'This girl can' campaign by Sport England, 2015.[7] Medway council has been running weekly sports sessions for women and girls as a part of this campaign to challenge the cultural assumptions about femininity and engagement in exercise.

Dr Natasha Kale, MTI Trainee
Medway NHS Foundation Trust

Drs Manisha Shah and Chee-Fone Chu,
Consultant Anaesthetists,
Medway NHS Foundation Trust

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7 This Girl Can (sportengland.org/funds-and-campaigns/this-girl-can).

NEW TO THE COLLEGE

To note 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, or Anaesthesia with Intensive Care Medicine or Pre-Hospital Emergency Medicine where highlighted.

October 2022

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Yusuf Ghumra

East of England
Joshua William Cain DUAL ICM
Nancy Qian Wang

Imperial
Sam Jonathan Haddad
Reema Patel

Kent, Surrey & Sussex
Kayur Patel
Natasha Jane Hughes
Rupert James Mason
Thomas Richard Dawes

Mersey
Alison May Evans

North Central London
Hasita Patel
Anjana Prasad
Leonora Katrina Bowen
Leopold Christof Constantin Prinz Zu Salm-Horstmar

North West
Hrishi Mekkali Narayanan

Northern
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Linden Sharon Baxter
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Anneke Janet Chu
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William Walter Gaunt DUAL ICM

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Kyria Rasheda Delana Roberson
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Warwickshire
Yassar Mustafa

Wessex
Charles Edward White DUAL ICM

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Natasha Nicole Sharma

West Yorkshire
Michelle Lisa Bradshaw
Samina Rahman Chowdhury

December 2022

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Zainab Abdirazack Sayed Hussein

Birmingham
Anna Jane Jordan

East Midlands
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East of England
Gabriella Wong
Rahul Sylvester Mudannayake

North West
Hannah Loren Greenlee
Martin Adam William Ince
Simon James Mackie
Thomas Dominik Vincent Markey

Northern
Simon Matthew Hill

Severn
Sarah Jane Dolling

Warwickshire
Amar Singh Jessel
Victoria Jane Bower

Wessex
Lewis Simon Matthews DUAL ICM
Hermione Harriet Tolliday
Paul Michael Gordon

West of Scotland
Michael George Gardner

West Yorkshire
Adam Allan Christoffer Young DUAL ICM

January 2023

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Ruth Hannah Bird

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Alexander Edward Midgley-Hunt DUAL ICM
Chris John Walmsley

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Rachel Louise Rowe
Sreyashi Sen

East Midlands
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Mark Kenneth Leslie Forth

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Katie Louisa Wimble
Philippa Louise Surgey

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Kate Mary Ann Smith

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Aisha Jalaly
Anish Dipak Amlani
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Alistair Cranfield DUAL ICM
Holly Marie Moxon
Kavita Sasi Kumar
Matthew John Terence Bigwood

Northern
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Northern Ireland
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Barry Jason Campbell
Ciara Crail

Oxford
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Nicolas Suarez
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Prabhjoyt Kaur Kler DUAL ICM

Wales
Anna Pisarczyk-Bathini
Douglas Robert Morgan

West of Scotland
Andrew William McGuire DUAL ICM

West Yorkshire
Naina Stannard
Sophie Earl

DEATHS

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

Dr Anne Florence

Dr Richard Hugh James

Dr Melville Kermack Milne

Dr Ralph Stephens Vaughan

Dr Amber Elizabeth Russell Young

To submit a Lives of the Fellows form for publication on our website (rcoa.ac.uk/lives-fellows-biography-listings), please contact archives@rcoa.ac.uk

APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

The College congratulates the following fellows on their consultant appointments:

Dr James Cook, Maidstone and Tunbridge Wells NHS Trust

Dr Ross Dryburgh, Sunderland Royal Hospital

Dr Sheshank Jajur, County Durham and Darlington NHS Foundation Trust

Dr Pav Sarai, Imperial College Healthcare

Dr James Shilston, Nottingham University Hospitals NHS Trust

Dr Nicolas Suarez, Oxford University Hospitals NHS Foundation Trust

Dr Vinayak Vanjari, Manchester University NHS Foundation Trust

Alexander Walls, St George's Hospital, London

Dr James Wright, York District General Hospital

ANNUAL COLLEGE AWARD NOMINATIONS

Do you feel someone you know should receive a College award for their work?

We are inviting nominations for the College's annual awards and Eponymous lectures. This is your chance to help the College recognise the specialty's unsung heroes. We are keen to receive as many nominations as possible from both the UK and overseas for all our awards and Eponymous Lectures.

The nominations proposal form (bit.ly/RCoANomForm) allows any Fellow or Member to put forward or second a nomination for consideration by the Nominations Committee. Past recipients and the Criteria for Honours, Awards and Prizes are listed on the College website (bit.ly/RCoAHonsAwardsPrizes) and should be used as a good starting point when considering what award a nomination should be submitted for.

Please use the nominations proposal form to complete your proposal and submit completed forms or queries to: awards@rcoa.ac.uk by **Friday 21 April 2023**.

We look forward to reading your nominations.

There is an easier way to administer Metaraminol

Aguettant ready to administer pre-filled syringes: a less risky alternative to ampoules.

Medication errors occur in an estimated 1 in 133 anaesthetics.[1-3]

Nearly a third of those medication errors cause an adverse drug event, which increases healthcare costs[3] and the likelihood of patient death.[3]

Therefore, as an anaesthetist, one of your largest challenges is reducing the risk to your patients during drug administration. Research shows pre-filled syringes (PFS) could significantly reduce that risk.[4]

Metaraminol pre-filled syringes could support you in keeping your patients safe.[5]

A straightforward and ready-to-administer alternative.

Medication errors can occur at any stage of the process, from the initial prescription, right through to administration.

Metaraminol, when drawn up from a 10mg ampoule, has many preparation steps potentially increasing the risk of medication errors.

Aguettant Metaraminol ready to administer pre-filled syringes have a luer compatible connection allowing needle free administration.

Created by experts; supporting The Royal Pharmaceutical Society Professional standards.[6]

Created by NHS supplier Aguettant, our pre-filled syringes comply with recommendations to use PFS made by:

- The Royal Pharmaceutical Society[6]
- The Royal College of Anaesthetists[7]

Helping you towards your environmental aims.

Considering all components used in the preparation steps of 10mg ampoules, your switch to Metaraminol pre-filled syringes could reduce your overall plastic use and the amount of waste you send to incinerators.

READY TO ADMINISTER PFS
REDUCING HUMAN ERROR

REFERENCES

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AGUETTANT
ESSENTIAL
MEDICINES

Metaraminol 0.5 mg/ml, solution for injection in pre-filled syringe.
Prescribing Information: Please refer to the Summary of Product Characteristics (SmPC) before prescribing Metaraminol.

Metaraminol: Each 5 ml pre-filled syringe contains 2.5 mg of metaraminol (as tartrate). Also contains 17.7 mg equivalent to 0.77 mmol of sodium.

Indication: Treatment of acute hypotension due to loss of vasoconstrictor tone as may occur during spinal anaesthesia and as an adjunct to accepted remedial procedures.

Dosage and administration: For intravenous use. Metaraminol 0.5 mg/ml, solution for injection should not be diluted before use. The Metaraminol 0.5mg/ml solution for injection in pre-filled syringe is not suitable for intravenous infusion and syringe pump drivers. Adults: direct intravenous injection in grave emergencies: 0.5 to 5 mg (1 to 10 ml). The maximum cumulative dose after repeated direct intravenous injections is 5mg. One direct IV injection should usually not exceed 1mg.Direct intravenous injection may be followed by an infusion of 15 - 100 mg in 500 mL of infusion using appropriate metaraminol formulation and administration. Children: Metaraminol should not be used in children under 12 years of age. Elderly: The dosage may not require modification for elderly; however, caution should be taken due to sensitivity to sympathomimetic agents.

Contraindications:
Hypersensitivity to metaraminol or to any of the excipients.
Concomitant use with cyclopropane or halothane anaesthesia.

Warnings and Precautions: Caution should be exercised to avoid excessive blood-pressure changes. Rapidly induced hypertensive responses have been reported to cause acute pulmonary oedema, cardiac arrhythmias and arrest. Use with caution with patients with cirrhosis, heart disease, hypertension, thyroid disease or diabetes mellitus. Sympathomimetic amines may provoke a relapse in patients with a history of malaria. When possible, choose the site for injection to avoid those areas generally recognised as being unsuitable for the use of any pressor agent, especially for patients with peripheral vascular disease, diabetes mellitus, Buerger's disease or conditions with coexistent hypercoagulability. In case of extravasation, local administration of an alpha blocker such as Phentolamine may prevent the risk of necrosis.

Interactions: Metaraminol should not be used with Cyclopropane or halothane anaesthesia, due to the risk of serious ventricular arrhythmia. The use with digitalis medicines can cause ectopic arrhythmic activity. Monoamine oxidase inhibitors potentiate the action of sympathomimetic amines. There is a risk of vasoconstrictions and/or hypertensive crisis in case of co-administration with ergot alkaloids Co-administration with tricyclic antidepressants, oxytocic drugs and doxapram enhance the effect of metaraminol and with guanethidine may alter the effects of both medications.

Fertility, pregnancy and lactation: Pregnancy: Should not be used during pregnancy unless clearly necessary. There are no well-controlled studies in pregnant women. Breastfeeding: It is not known whether metaraminol is secreted in human milk. Caution should be exercised if metaraminol is given to a breastfeeding mother. Fertility: There are no fertility data available.

Undesirable effects: Psychiatric disorders: Anxiety, fear, confusion, irritability, psychotic state. Nervous system disorders: Headache, Restlessness, dizziness, insomnia. Cardiac disorcers: Palpitations; sinus or ventricular tachycardia; bradycardia; other cardiac arrhythmias (especially in patients with myocardial infarction); fatal ventricular arrhythmia reported in Laennec's cirrhosis. Vascular disorders: hypertension, flushing, rebound hypotension, peripheral ischaemia. Gastrointestinal disorders: Nausea, vomiting. Renal and urinary disorders: Difficulty in micturition, urinary retention. General disorders and administration site conditions: Abscess formation; tissue necrosis; sloughing, sweating.

Overdose: Refer to SmPC.

Special precautions for storage: Keep the syringe in its unopened blister until use. Do not freeze.

Legal Category: POM

Pack size: Pre-filled syringe, available in box of 10. **Price list**: £95.00 per box of 10.

MA Number: PL 14434/0042

MA Holder: LABORATOIRE AGUETTANT, 1, rue Alexander Fleming, 69007 Lyon, France **UK Distributor**: Aguettant Ltd, No. 1, Farleigh House, Flax Bourton, Bristol, BS48 1UR, United Kingdom

Full SmPC available from the UK Distributor.

Date of preparation:12/08/2021. Unique ID no PI0042/002

Adverse events should be reported. Reporting forms and information can be found at http://yellowcard.mhra.gov.uk/ Adverse events should also be reported to Aguettant Limited on +44 1275 463 691

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www.metaraminol.co.uk

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Course fee: Consultant Anaesthetist: £150
SAS/Trainee Anaesthetist: £120

One ODP/ Nurse can accompany free as a team from the same hospital. Individual anaesthetists and theatre team members are welcome to apply (ODP/ Nurse Course fee £75)

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(1I02, 1I03, 1B02, 1C02, 2A01)

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Coventry Bronchoscopy Course

6th September 2023

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- Human Factors in Bronchoscopy
- ORSIM bronchoscopy Simulator
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- Scope handling & pitfalls
- Pulmonary anatomy
- Difficult airway & Bronchoscopy
- Bronchoscopy for BAL
- Pulmonary haemorrhage
- Tracheostomy in critical Care
- Post-bronchoscopy care

Registration fee: £110
Includes breakfast, lunch and refreshments

NHS University Hospitals Coventry and Warwickshire NHS Trust

Coventry Neurosimulation Course

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A one day course for consultants and trainees in Anaesthesia and Critical Care, provides a structured approach in managing time critical neuro-emergencies. The course enables to understand role of human factors in managing neurosurgical emergencies. Also provides skills and knowledge of anaesthesia at remote locations.

The programme includes two interactive lectures followed by workshops and high fidelity simulated scenarios.

- Transfer of critically injured patient
- Human factors & crisis
- Cardiac arrest in prone position
- Simulation scenarios
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- Hyperacute Stroke management

Registration fee: Consultant: £160
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Includes breakfast, lunch and refreshments

For further information please visit: https://www.mededcoventry.com/courses/Anaesthetics
Please contact Rachel Davies on courses@mededcoventry.com or call 024 7696 8722

15th May 2023

23rd ANNUAL SCIENTIFIC MEETING

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Building your portfolio

- Submit articles on educational topics for free. These are published in our biannual newsletter or in the RCoA Bulletin magazine
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Thank you, and we look forward to you joining: https://www.seauk.org/join-seauk

Cyprian Mendonca	Peeyush Kumar	Claire Halligan	Umair Ansari
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RCoA Royal College of Anaesthetists

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Anaesthetic updates

Online | 14-15 June 2023

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Birmingham and Online

SPEAKERS:

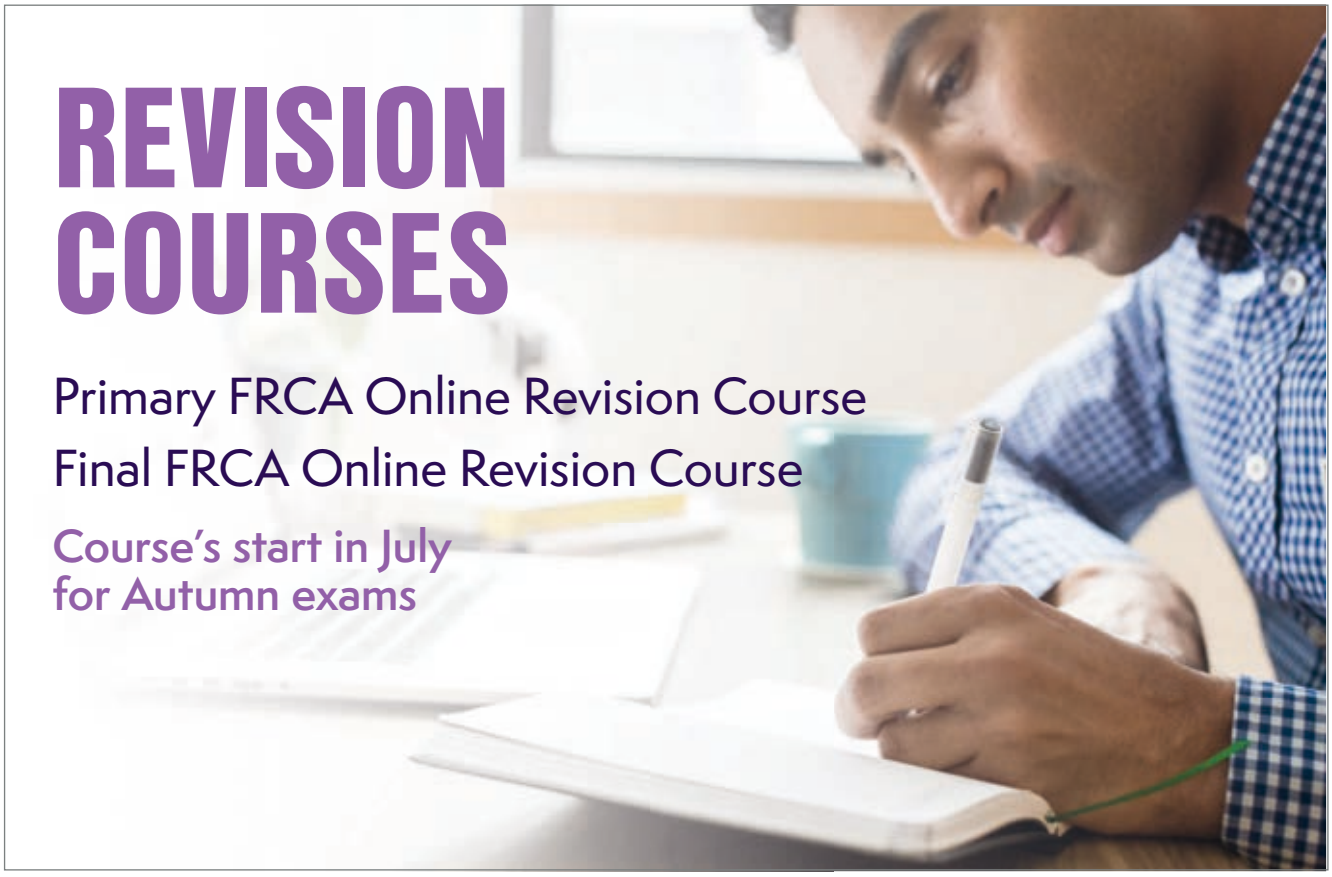
COLONEL JAMES RALPH, BIRMINGHAM
Lessons from conflict - let's not forget

DONNA OCKENDEN, SOUTH EAST
A year on from Ockenden, where are we now?

DR ALLAN CYNA, AUSTRALIA
Language, nocebo and hypnocommunication

DR SEEMA QUASIM, BIRMINGHAM
Ethnic disparities in obstetric anaesthesia outcomes

Book your place at: rcoa.ac.uk/anaesthesia

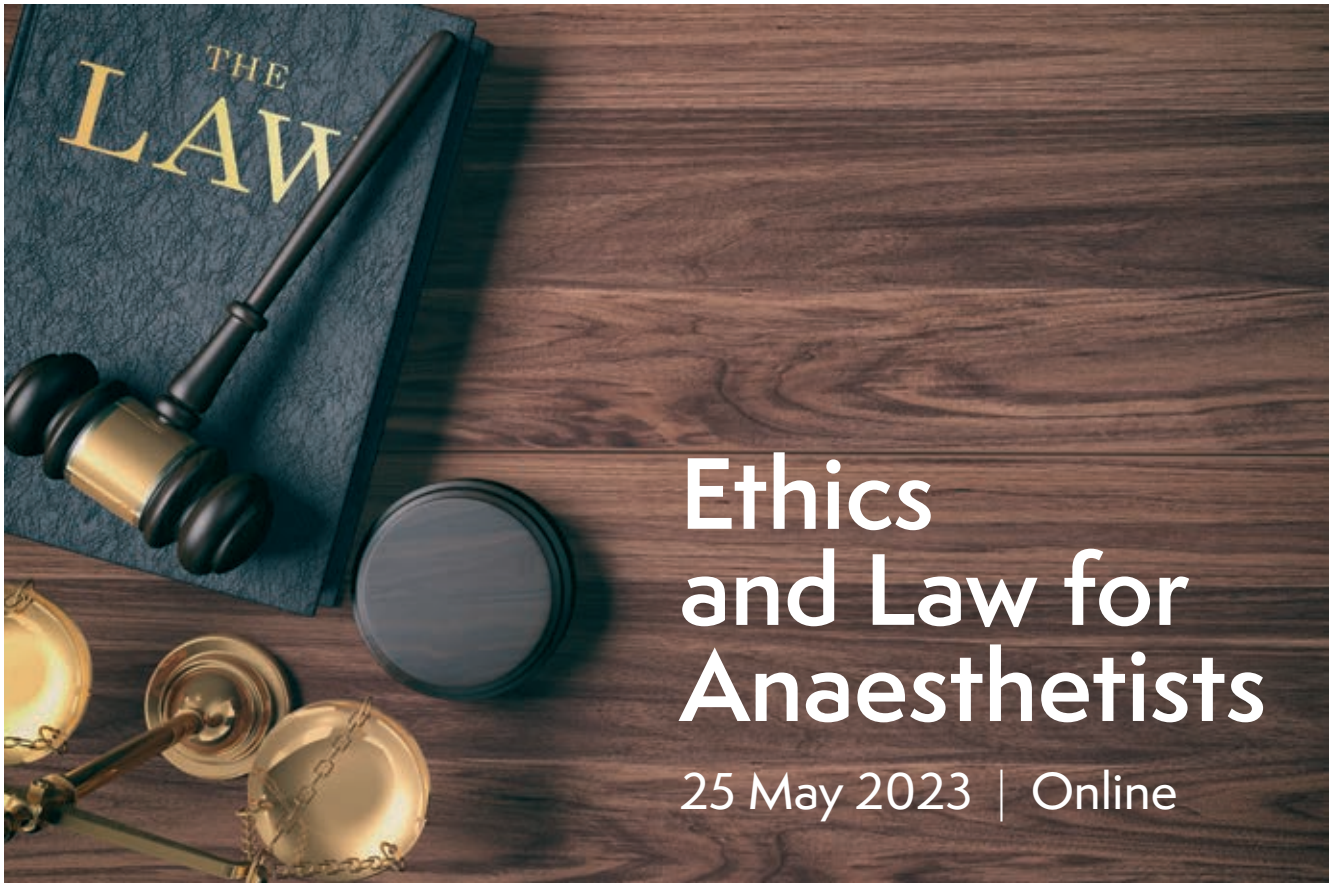


REVISION COURSES

Primary FRCA Online Revision Course

Final FRCA Online Revision Course

Course's start in July
for Autumn exams



Ethics and Law for Anaesthetists

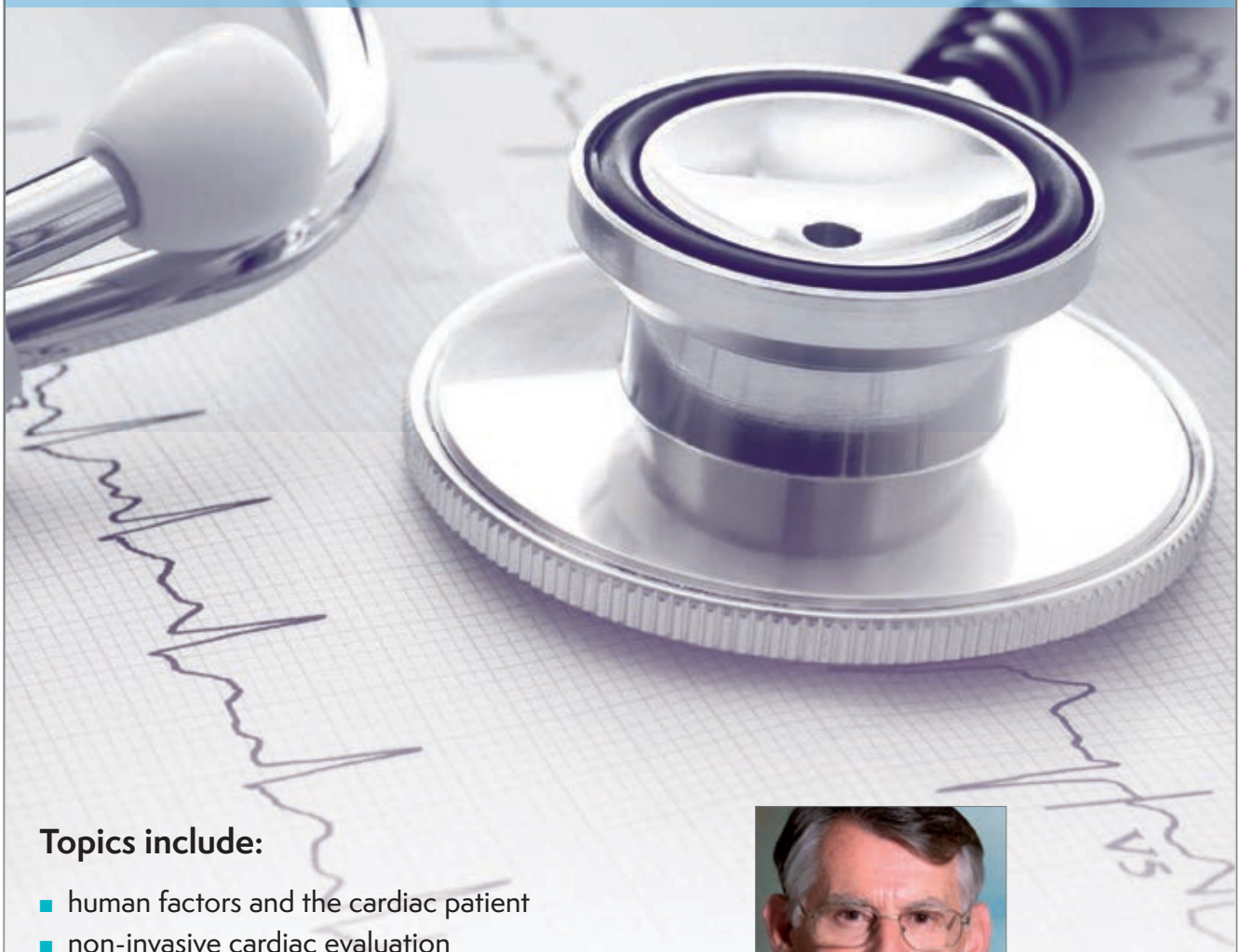
25 May 2023 | Online

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

Book your place at rcoa.ac.uk/events

Cardiac Disease and Anaesthesia Symposium

26–27 April 2023 | RCoA, London and online



Topics include:

- human factors and the cardiac patient
- non-invasive cardiac evaluation
- pathophysioiogy of pulmonary hypertension
- anaesthesia for patients with valvular heart disease
- heart disease in pregnancy
- concerns about arrhythmias
- the place of ECMO in 2023.

Programme brought to you by Professor Pierre Foëx and Professor Helen Higham.

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

MSA

Mersey School of Anaesthesia

"If you feed the children with a spoon, they will never learn to use the chopsticks."

★REMOTE LEARNING★

Final FRCA Written CRQ E-Club

for the **Final Written Examination September 2023**

Starting April 2023

A peer learning opportunity to improve your readiness for the Final FRCA Written via the use of our bespoke online platform.

Benefits Include;

★ Timed & Disciplined Practice ★
★ Acquisition of useful Answer Guidances from Other Members ★
★ Valuable Motivation towards Sustained Revision ★
★ 10% Discount & Priority Application to the Booker & SBA Course(s) in August 2023 ★

Candidates are urged to join by April 2023 to gain Maximum Benefit.

Apply or Register Interest via the Website

★FACE TO FACE COURSES★

Primary & Final FRCA Viva Courses

for the May & June 2023 FRCA SOE Examinations

The 'Magic Roundabouts'
In-Person 3-Day Intensive Course
Peer-to-Peer
Practice, Presentation & Technique

The 'Booker' Course

for the September 2023 Final FRCA Written Examination

An Online 5-Day Intensive Course
12-Question CRQ E-Papers & Review
SBA Interactive Sessions
Presentations on Key Points for Various FRCA Sub-Specialties

Primary & Final FRCA SBA/MCQ Courses

for the September 2023 FRCA Written Examinations

In-Person 6-Day Intensive Course
Group Work
SBA & MCQ Analysis & Discussion

Courses for the Royal College of Anaesthetists Examinations

Courses	Dates 2023/24		Capacity
Primary FRCA SBA/MCQ	**6th – 11th August 2023**	**October 2023**	**70**
Final FRCA SBA/MCQ	**13th – 18th August 2023**	**February 2024**	**70**
The 'Booker' Course	**20th – 24th August 2023**	**February 2024**	**90**
Primary FRCA Viva Course	**9th – 11th May 2023**	**October 2023**	**60**
Final FRCA Viva Course	**13th – 15th June 2023**	**November 2023**	**60**

For confirmations and updates visit us at:

www.msoa.org.uk

@merseyschoolofanaesthesia @MSA_Courses @merseyschoolofanaesthesia

PLEASE NOTE:

Trainees planning on taking part in MSA Courses must appreciate that the MSA Courses are designed for Exam Preparation only, and include:

- *Exposure to Exam Style Questions*
- *Opportunities to Practise*
- *Learn & Fine-Tune Exam Techniques*
- *Peer Learning*

They are not designed to Teach. The advice to Trainees is that they should only attend MSA Courses when they consider themselves adequately Prepared for the Imminent Examinations.

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*Concentric accepts no responsibility for your relationship success (or otherwise). Sorry.