Royal College of Anaesthetists

ACSA Annual Forum 2025

Wednesday 9 July 2025

Housekeeping

- No planned fire alarm tests
- Refreshment break at **11:05am** and lunch at **12:45pm** will be served in the Café on the ground floor
- Photography throughout the day – don't want photos taken? Please make yourself known to a member of the ACSA team
- Please ensure all mobile devices are turned onto silent mode

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Wifi

- Wifi network: **Rcoa**
- Password: **rcoa-purple**

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Q&As

- AM: Throughout the morning sessions, please raise your hand to ask your question at the end of the speaker's talk and we'll pass you a microphone 

- PM: **Sli.do** for **Final Q&A panel at end of the day**, please use QR code below and submit your questions throughout the day
- Please upvote the questions you want to be answered

slido

#ACSA2025

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Workshop

12:45-13:45	**LUNCH**	
Session 3	**Workshop**	
13:45-14:45	Tricky Standards Workshop	Dr Kate Glennon, ACSA Committee Vice Chair
Session 4	**Q&A with All Speakers**	
14:45-15:45	ACSA Panel Discussion and Open Forum	All speakers

After lunch:

- Group number is on your badge
- Groups 1-6 = Gallery 1
- Groups 7-11 = Gallery 2

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Agenda

ACSA Annual Forum Programme
Wednesday 9th July 2025
Royal College of Anaesthetists, London, WC1R 4SG

09:30-10:00	**REGISTRATION AND REFRESHMENTS**	
Session 1	**The ACSA Standards**	
10:00-10:10	Welcome and Introduction	Dr Jon Chambers, ACSA Chair and Clinical Lead
10:20-10:45	2025 ACSA Standards: Key Changes and Domain 5 Integration	Dr Adrian Jennings, Russells Hall Hospital, Dudley & Dr Nick Spittle, Chesterfield Royal Hospital
10:45-11:05	The new ACSA Standard on Perioperative Allergy	Dr Amy Dodd, North Bristol NHS Trust
11:05-11:30	**REFRESHMENTS**	
Session 2	**The ACSA Process**	
11:30-11:40	ACSA Updates: What's new on the portal	Ms Ruth Nichols, Head of Clinical Quality
11:40-12:00	Involving anaesthetists in training in the ACSA review process	Dr Tallulah Boddy, Royal Cornwall Hospitals NHS Foundation Trust
12:00-12:20	A Lay Reviewers' Perspective	Mr Stuart Burgess, ACSA Lay Reviewer
12:20-12:45	Preparing for ACSA: Tips, pitfalls and helpful hints	Dr Maria Garside & Dr Sarah Goellner, Bradford Teaching Hospitals NHS Foundation Trust
12:45-13:45	**LUNCH**	
Session 3	**Workshop**	
13:45-14:45	Tricky Standards Workshop	Dr Kate Glennon, ACSA Committee Vice Chair
Session 4	**Q&A with All Speakers**	
14:45-15:45	ACSA Panel Discussion and Open Forum	All speakers

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ACSA 10th ANNIVERSARY
Anaesthesia Clinical Services Accreditation

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Why ACSA?

"Requests have come from departments and employers for proactive and supportive professional advice about best practice in the organisation and provision of anaesthetic clinical services in the NHS environment"

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My ACSA ‘journey’

- Departmental ‘interest’ in ACSA
- Became ACSA lead for dept
- Became a reviewer
- Co-opted onto ACSA Committee

- Seen the benefits of the process from both sides

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ACSA: The Process

- **Voluntary** scheme = Quality Improvement through **peer review**
- Department benchmarks their performance against a set of 155 standards taken from the Guidelines for the Provision of Anaesthetic Services (GPAS)* 2025 standards
  - priority 1 (144) = must meet
  - priority 2 (10) = standard in development
  - priority 3 (1) = aspirational standard
- A team of trained reviewers are **invited** to visit the department to validate **the self-assessment of the organisation**
- When the organisation meets all the required standards their achievement is recognised by the College

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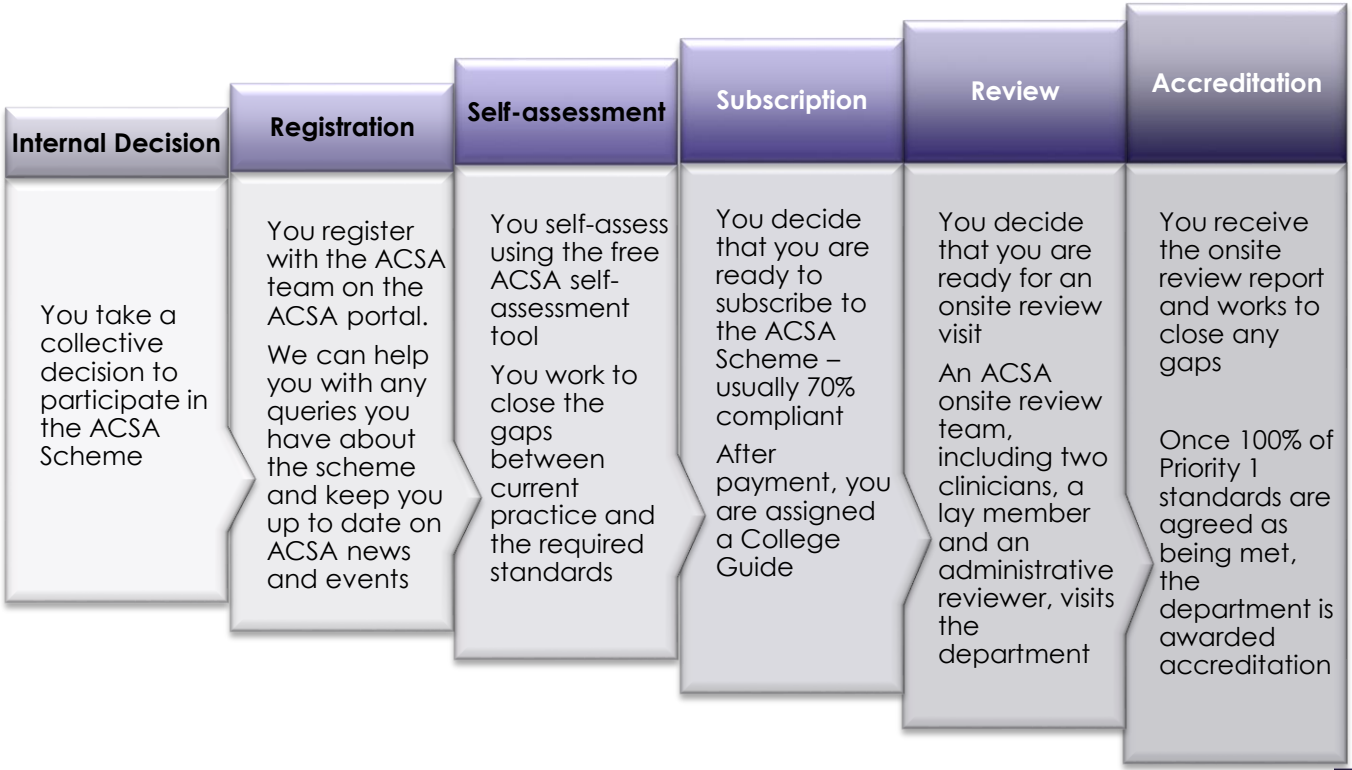
ACSA: The Process



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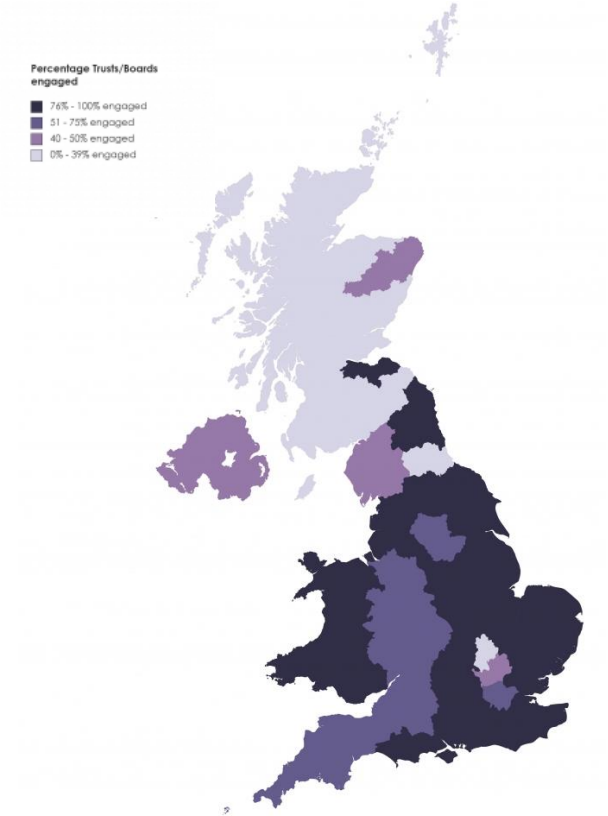
Who is engaged with ACSA?



- 131 registered departments (80%)
  - 86% in England
- 77 departments are subscribed to ACSA
- 61 accredited departments (35%)
  - 59 (41%) in England

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The origin of the ACSA Standards

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The ACSA Standards 2025: DOMAINS

1. The Care Pathway
2. Equipment, Facilities & Staffing
3. Patient Experience
4. Clinical Governance
5. Subspecialties (Cardiac, Neuro, Vascular, Ophthalmic)

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The ACSA Standards 2025: DOMAINS

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The ACSA Standards 2025: SUBDOMAINS

1. **The Care Pathway**
   - **1.1 Policies**
     - General
     - Non-theatre environment
     - High Risk Patients
   - **1.2 Before the procedure**
     - Pre-assessment
     - Consent
   - **1.3 On the day of the procedure**
     - Intraoperative period
     - Services
   - **1.4 Post Procedure**
     - Recovery
     - Recovery Staff
     - Escalation of care
     - Review and Discharge
     - Pain Management
   - **1.5 Emergency Surgery**
     - Emergency Care Pathway
   - **1.6 Paediatrics**
     - General
     - Policies
     - Critically Ill Children
   - **1.7 Obstetrics**
     - Policies
     - Staffing
     - Facilities

2. **Equipment, Facilities & Staffing**
   - **2.1 Equipment**
   - **2.2 Drugs, fluid and blood**
   - **2.3 Anaesthetic Records**
   - **2.4 Facilities**
   - **2.5 Staffing**

3. **Patient Experience**
   - **3.1 Patient Information**
     - Patient Decision Making
     - Communication
   - **3.2 Care of the individual**
     - Dignity
     - Patients with Additional Needs

4. **Clinical Governance**
   - **4.1 Departmental Management**
     - Planning
     - Leadership
     - Culture
   - **4.2 Learning from Experience**
     - Incident reporting
     - Audit and QI
     - Outcome Measurement
   - **4.3 Workforce**
     - Recruitment
     - Induction

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THE STRUCTURE OF A STANDARD

The ACSA standard has **5 DOMAINS:**

1 The Care Pathway
2 Equipment, Facilities and Staffing
3 Patient Experience
4 Clinical Governance
5 Subspecialties

These are broken down further into **SUBDOMAINS** and **AREAS**

KEY

DOMAIN — SUBDOMAIN — AREAS — STANDARD

The ACSA standards have been mapped against the Care Quality Commission Key Lines of Enquiry, Health Inspectorate Wales and Health Improvement Scotland inspection domains

Guidelines for the Provision of Anaesthetic Services references.

[illegible] has to be a **definitive statement** which warrants a 'yes' or 'no', 'met' or 'unmet' response.

			PRIORITY	[illegible]OC KLoE, HIW and [illegible]HIS Domains	GPAS REFERENCES	HELP NOTE
1.	The Care Pathway					
1.1	General					
1.1.1	Policies					
1.1.1.1	All patients should have a named and documented supervisory anaesthetist who has overall responsibility for the care of the patient	This should be visible on the anaesthetic record, on the rota, on display in the department and visible in the obstetric area	1	Safe Effective Well-led Safe & effective care Safe, effective and person-centred care delivery	3.4.6 9.1.19, 9.1.20 10.1.4	This additional wording has been produced to clarify the standard where possible and has been agreed by the ACSA Committee.

Each **STANDARD** has a number. If a standard is removed, the number is not re-used, so some numbers are missing where standards have been taken out during the editing process. The standards themselves are grouped into these areas so that the standards are categorised and easy to find.

The text underneath each standard describes the evidence required to determine whether or not that standard is met.

Standards are either listed as Priority 1, Priority 2 or Priority 3.
Priority 1 standards must be achieved in order for accreditation to be awarded.
Priority 2 standards are aspirational, but may not be achievable because of mitigating circumstances (e.g. resource or geography issues) and may form part of ongoing issues.
Priority 3 standards provide targets for the highest performing departments to achieve.

The standards all have one or more references to the GPAS document.

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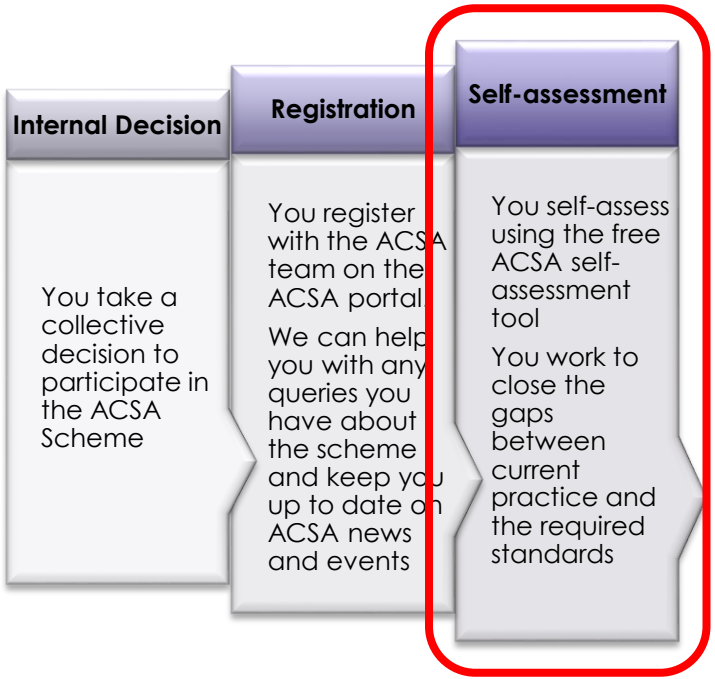
ACSA: The Process



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Do you meet the ACSA Standard?

- 4 key questions……

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Do you meet the ACSA Standard?

1. What does the standard require?
2. How should we rate ourselves & why?
3. What evidence can we provide to support our assessment?
4. Met, Not Met or Not applicable

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Where to start?

- Self-assessment against the ACSA standards
  - What are our strengths and weaknesses?
  - What is the size of the gap between current practice and meeting the ACSA standards?
- Communication with colleagues – clinical and non-clinical
  - Involving as many people as possible from the start will make it easier to identify problem areas
  - Share the load
  - Management support is essential
- Improvement – what and how can we improve?
  - Some improvements will be straight forward to implement, even before the department is formally engaged with ACSA
  - Other improvements will take more effort and the College will offer help from experienced clinicians and via examples of good practice

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How did we approach ACSA?

- Departmental agreement at the start
- Lead roles agreed
- Divided up standards into clinical areas

- Regular review of progress
- Carrot vs Stick
- Deadline – book the date of ACSA Visit

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What did ACSA ever do for us...?

- Gave the department a common purpose
- Shone a light on areas of 'old' practice
- Opportunity to further develop new initiatives (POM, Pre-assessment, PROMS)
- Raised our profile within Trust/Region
- Helped us review our process post pandemic

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ACSA - 10 years in numbers...

- As a result of their ACSA review:
  - 20 departments have increased the provision of capnography throughout the patient journey
  - 11 departments have improved preoperative assessment services, both adult and paediatric through increasing consultant sessions within the service
  - 9 departments have introduced or expanded a separately staffed elective theatre for their maternity services

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New Standards 2025

Dr Adrian Jennings
Consultant Anaesthetist, The Dudley Group NHSFT
Member of the ACSA Committee

Dr Nick Spittle
Consultant Anaesthetist, Chesterfield Royal Hospital
Member of ACSA Committee

A double act

- ACSA standards reviews
- Overview of 2025 changes
- In detail discussion of new standards
- Time for questions

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A little history

- ACSA launched in 2014
- Annual review of standards until 2022
- Now 3-yearly review of standards

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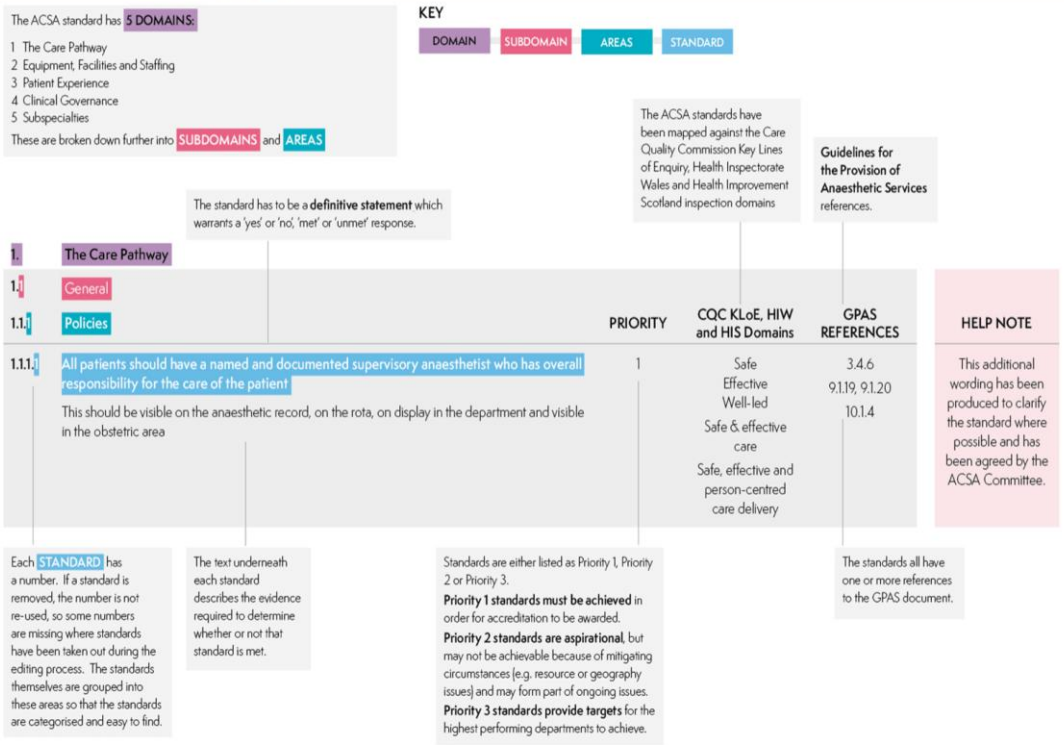
THE STRUCTURE OF A STANDARD



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Current ACSA domains

- 1 – The care pathway
- 2 – Equipment, facilities & staffing
- 3 – Patient experience
- 4 – Clinical Governance
- 5 – Anaesthesia subspecialty
  - Cardiothoracic services
  - Neuroanaesthesia & neurocritical care
  - Ophthalmic services
  - Vascular services

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Prioritisation of standards

- **One**
  - Must be achieved for accreditation
- **Two**
  - Should be achievable for most departments
- **Three**
  - Aspirational for most departments

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ACSA standards review process

- Initial consultation & call for suggestions
  - ACSA accredited departments
  - ACSA committee members
  - Specialist societies
  - Wider RCOA, including Patient Voices representatives
- Standards Review Day
- Draft changes debated at ACSA committee meeting
- Final consultation period
- Finalised changes signed off by RCOA

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Changes made to the standards in 2023

- New standards

  1
- Deleted standards

  4
- Priority changed

  10
- Additions or amendments

  45

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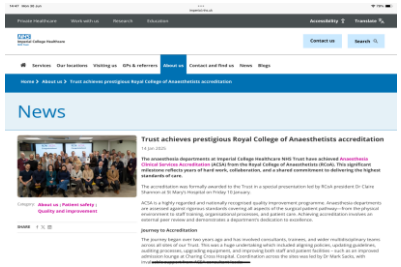
Issues with Domain 5

- Only covers 4 subspecialties
- Opt –in, unless your hospital only does that subspecialty,& costs more.
- Also covers (some) critical care of subspecialty patients
- Not separately identified on ACSA accreditation plaques !
- Potential for stakeholder confusion



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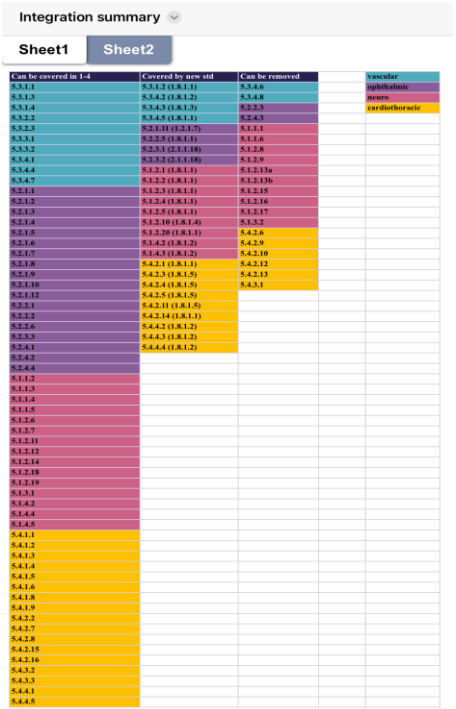
2025 Standards Review – Domain 5 changes

- To assess and remove all 106 Domain 5 standards
- 61 Domain 5 standards already covered in D1-4
- 25 can be covered by new standards in Domains 1-4
- 20 can be removed completely


Integration summary

Sheet1 Sheet2

Can be covered in 1-4	Covered by new std	Can be removed		
5.3.1.1	5.3.1.2 (1.8.1.1)	5.3.4.6		vascular
5.3.1.3	5.3.4.2 (1.8.1.2)	5.3.4.8		ophthalmic
5.3.1.4	5.3.4.3 (1.8.1.3)	5.2.2.3		neuro
5.3.2.2	5.3.4.5 (1.8.1.1)	5.2.4.3		cardiothoracic
5.3.2.3	5.2.1.11 (1.2.1.7)	5.1.1.1		
5.3.3.1	5.2.2.5 (1.8.1.1)	5.1.1.6		
5.3.3.2	5.2.3.1 (2.1.1.18)	5.1.2.8		
5.3.4.1	5.2.3.2 (2.1.1.18)	5.1.2.9		
5.3.4.4	5.1.2.1 (1.8.1.1)	5.1.2.13a		
5.3.4.7	5.1.2.2 (1.8.1.1)	5.1.2.13b		
5.2.1.1	5.1.2.3 (1.8.1.1)	5.1.2.15		
5.2.1.2	5.1.2.4 (1.8.1.1)	5.1.2.16		
5.2.1.3	5.1.2.5 (1.8.1.1)	5.1.2.17		
5.2.1.4	5.1.2.10 (1.8.1.4)	5.1.3.2		
5.2.1.5	5.1.2.20 (1.8.1.1)	5.4.2.6		
5.2.1.6	5.1.4.2 (1.8.1.2)	5.4.2.9		
5.2.1.7	5.1.4.3 (1.8.1.2)	5.4.2.10		
5.2.1.8	5.4.2.1 (1.8.1.1)	5.4.2.12		
5.2.1.9	5.4.2.3 (1.8.1.5)	5.4.2.13		
5.2.1.10	5.4.2.4 (1.8.1.5)	5.4.3.1		
5.2.1.12	5.4.2.5 (1.8.1.5)			
5.2.2.1	5.4.2.11 (1.8.1.5)			
5.2.2.2	5.4.2.14 (1.8.1.1)			
5.2.2.6	5.4.4.2 (1.8.1.2)			
5.2.3.3	5.4.4.3 (1.8.1.2)			
5.2.4.1	5.4.4.4 (1.8.1.2)			
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5.4.2.15				
5.4.2.16				
5.4.3.2				
5.4.3.3				
5.4.4.1				
5.4.4.5				

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Changes made to the standards in 2025

- New standards

  8
- Deleted standards

  111 (106 from Domain 5)
- Priority changed

  2
- Additions or amendments

  44

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New Standards

- 3 in Care Pathway
- 1 in Equipment, Facilities and Staffing
- 4 in Clinical Governance

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"All new standards are assigned to Priority 2 in their first year but may become Priority 1 after that."

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1.2.1.7
Where appropriate, anaesthetists contribute to MDT pathways within relevant patient pathways.

EVIDENCE REQUIRED

Mechanisms for input to MDT meetings. Anaesthetists who are required to attend MDT meetings confirm that this is recognised in their job plans. Local clinical pathway/policies show evidence of multidisciplinary input where appropriate. Evidence of shared learning from relevant specialty M&M and audit meetings.

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1.2.1.8
Guidelines are in place for the prevention and management of postoperative cognitive dysfunction and postoperative delirium.

EVIDENCE REQUIRED

Copy of guidelines provided. Verbal confirmation from staff that guidelines are followed.

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1.2.1.9
Policies are in place for the management of perioperative allergy, including referrals to allergy clinics where appropriate.

EVIDENCE REQUIRED

Copy of policy provided. The policy should include processes for patients who suffer suspected perioperative allergic reactions and pathways for patients who meet the criteria to be referred to a specialist allergy clinic for investigation. Clinical governance arrangements for suspected perioperative allergic reactions should be specified. Verbal confirmation from staff that policies are followed.

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2.1.1.18

Specialised monitoring and equipment appropriate to the surgery undertaken is available with staff who are trained and competent to use it. This is adequately maintained.

EVIDENCE REQUIRED

Presence of equipment appropriate to anaesthetic services provided. Staff should confirm that they are trained and competent in its use.

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4.3.3.8

The department has processes in place to regularly review Specialist, Specialty, Locally Employed Doctor and Fellow posts, to ensure that they best support the individual and contribute to career progression.

EVIDENCE REQUIRED

Verbal confirmation of processes from Clinical Director and relevant staff groups.

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4.3.3.9

All anaesthetists within the department (including Specialists, Specialty, Locally Employed Doctors and Fellows) should be provided with the support to enable career development. This should include, but is not limited to, educational supervision, pastoral care and access to study leave.

EVIDENCE REQUIRED

Evidence of opportunities for education supervision, opportunities for leadership and educational roles, and mentorship programmes (if available) should be provided. Specific groups should be interviewed about their practices and training.

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4.3.3.6
Anaesthetic provision for elective sub-specialist surgery is delivered by a group of consultant or autonomously practising anaesthetists who maintain current competency in that subspecialty area.

EVIDENCE REQUIRED

Staff should confirm that they have appropriate opportunities for sub-specialty CPD.

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4.3.3.7

Those consultants or autonomously practising anaesthetists who provide emergency cover to sub-specialty clinical areas but who do not undertake regular anaesthetic practice in that sub-specialty have time to attend appropriate CPD and attend sub-specialty surgery lists in a supernumerary capacity.

EVIDENCE REQUIRED

Verbal confirmation from those who deliver emergency sub-specialty anaesthesia out of hours.

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Timeline

Have now been published

Portal – next few weeks following web development

Departments recertifying >3 months will follow the new standards

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ACSA Standard on Perioperative Allergy

Dr Amy Dodd
Consultant Anaesthetist North Bristol NHS Trust
PAN Steering Committee
amy.dodd@nbt.nhs.uk

Overview

- Perioperative Allergy Network (PAN)
- ACSA Standard in Perioperative Allergy
- What can PAN do to help?

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Perioperative Allergy Network

Association of Anaesthetists

British Society for Immunology CIPN Clinical Immunology Professional Network

BSACI Improving Allergy Care through education, training and research

The Royal College of Pathologists Pathology: the science behind the cure

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ispar

Royal College of Physicians

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PAN

- >200 members- anaesthetists/allergists/immunologists
- Training and educational events
- Publications

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Perioperative Allergy Network

Perioperative Allergy Network recommendations for deciding which patients to refer for investigation of suspected perioperative hypersensitivity reactions

There is variability in the referral patterns for investigation of suspected perioperative allergy, particularly in respect to the referral of minor or cutaneous reactions.

In line with the European Academy of Allergy and Clinical Immunology[1], the Perioperative Allergy Network states the following:

1. Any patient with a suspected hypersensitivity reaction of modified Ring and Messmer grade 1-4 should be referred for investigation, irrespective of the results of mast cell tryptase sampling

In light of the r… a possible link t… Network has v…*

Allergic reactio… estimates in th… patient may su… problem is only… risk factor appe…

…g has been …ative of the …aph of any rash …tep

…l, Voltolini S, …actions. Allergy.

Peri-operative anaphylaxis

For anaesthetists/intensivists

A = Airway **B** = Breathing **C** = Circulation **D** = Disability **E** = Exposure

Diagnosis – look for:
- Unexplained hypotension, tachycardia, bradycardia, bronchospasm (wheeze may be absent if severe)
- Unexpected cardiorespiratory arrest where other causes are excluded
- Skin signs are often absent in severe reactions

Call for HELP
Stop/remove non-essential surgery. Call for cardiac arrest trolley

Stop/remove suspected triggers if possible
e.g. Antibiotics, NMBAs, dyes, colloids, chlorhexidine coated lines/catheters, lubricants , latex

Give initial IV bolus of adrenaline

Adult and child > 12 years: 50 micrograms IV (0.5 mL IV of 1 mg/10 mL [1:10,000])

Child < 12 years: 1 microgram/kg, needs careful dilution, titrate to effect

If no IV access: 10 micrograms/kg IM, (max 500 micrograms IM) of 1 mg/mL (1:1,000), and secure IV/IO access

If in doubt, give adrenaline

&

Give rapid IV fluid bolus

Adult and child > 12 years: 500–1000 mL

Child < 12 years: 20 mL/kg

- Multiple fluid boluses may be needed (e.g. up to 3-5 L in adults, 60-100 mL/kg in children)
- Avoid colloid

If poor response to adrenaline boluses, start IV infusion*
Involve ICU team early

If systolic BP < 50 mmHg or cardiac arrest, start CPR

A B = Airway/Breathing

Give 100% oxygen Ensure sustained $ETCO_2$ trace. Change to inhalational anaesthetic if appropriate.

Severe/persistent bronchospasm:
- Exclude oesophageal intubation
- Check patent airway and anaesthetic circuit
- Nebulised salbutamol and ipratropium
- Consider IV bronchodilator

C = Circulation

Hypotension may be resistant, requiring prolonged treatment with large volume resuscitation
- Give further fluid boluses, titrate to response
- Consider head-down table-tilt or elevating legs
- Establish invasive monitoring as soon as practical

IF REFRACTORY TO ADRENALINE INFUSION:
- Add a second vasopressor (noradrenaline or vasopressin) **in addition** to adrenaline
- Consider glucagon 1 mg IV in adults on beta-blockers
- Consider steroids for refractory reactions or shock
- Consider extracorporeal life support

Immediate follow-up
- Take blood (clotted) for serum tryptase once stable
- Request further samples 1–4 hours after onset of symptoms, and at least 24 hours later
- Complete allergy referral form: **bit.ly/NAP6referral**
- If surgery is urgent or time-critical and patient is stable, proceed with surgery but avoid suspected triggers

***Use local protocol for adrenaline infusion**
(Peripheral infusion recommended if no central venous access)

OR

Peripheral low-dose IV adrenaline infusion (if no local protocol):

0.5 mg (0.5 mL of 1 mg/mL [1:1000]) in 50 mL
- In both adults and children, start at 0.5–1.0 mL/kg/hour, and **titrate according to clinical response**
- Continuous monitoring and observation is mandatory

Resuscitation Council UK · Association of Anaesthetists · BSACI Improving Allergy Care · CIPN · RCoA Royal College of Anaesthetists · Perioperative Allergy Network

Association of Anaesthetists · CIPN · BSACI Improving Allergy Care

ACSA Standard in Perioperative Allergy

- **1.2.1.9 Policies are in place for the management of perioperative allergy, including referrals to allergy clinics where appropriate**

- **EVIDENCE REQUIRED**
- *Copy of policy provided.*
- *The policy should include processes for patients who suffer suspected perioperative allergic reactions and pathways for patients who meet the criteria to be referred to a specialist allergy clinic for investigation.*
- *Clinical governance arrangements for suspected perioperative allergic reactions should be specified.*
- *Verbal confirmation from staff that policies are followed.*

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ACSA Standard in Perioperative Allergy

- **1.2.1.9 Policies are in place for the management of perioperative allergy, including referrals to allergy clinics where appropriate**
- **PRIORITY** 2
- **CQC KLoEs**
  Safe, Effective, Responsive, Well-led
- **HIW Domains**
  Safe and effective care
- **HIS Domains**
  Safe, effective and person-centred care delivery; Policies, planning and governance

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ACSA Standard in Perioperative Allergy: GPAS references

- **2.1.15** … policies covering the entire perioperative period should be held and easily accessible for the management of patients with …:

- **allergies, including perioperative management of latex and chlorhexidine allergies**

- **Helpnote:** Chlorhexidine-free box

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ACSA Standard in Perioperative Allergy: GPAS references

- **2.4.1** Objective assessment of risk should be routine and the **identification of increased risk should trigger advanced planning** specific to that patient… This assessment should be based on:

- **medication history and allergy status**

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ACSA Standard in Perioperative Allergy: GPAS references

- **2.4.9** …**internal referral pathways to other specialties** should be in place for the minority of cases in which this may be required **to expedite further investigation and patient optimisation**.

- *Anaesthetist's responsibility to refer (ideally consultant and in communication with Anaesthetic Allergy Lead)*

- **Helpnote**:
  - PAN guidance on who to refer
  - NAP6 tools

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Specialist allergy referral

- PAN recommendations

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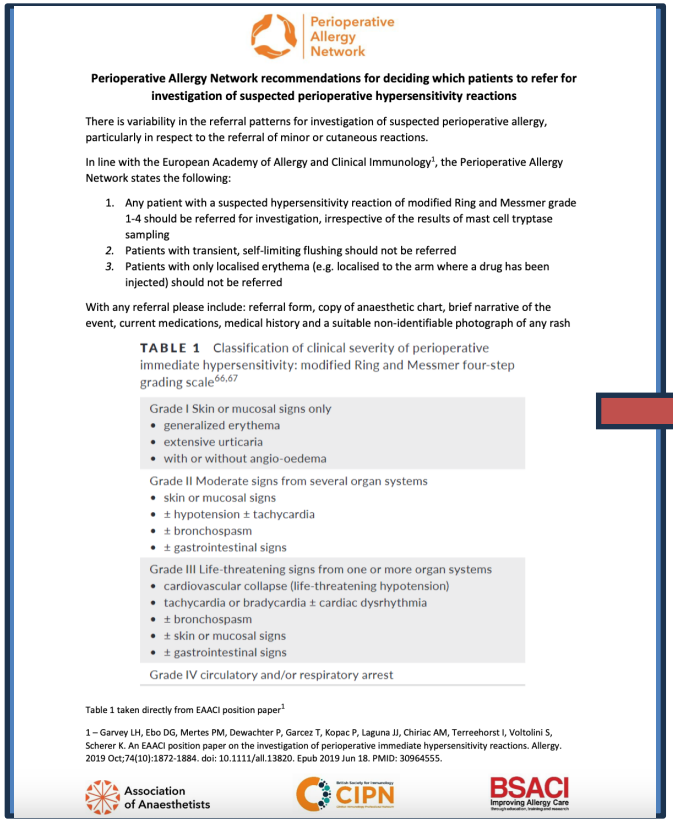

Perioperative Allergy Network

Perioperative Allergy Network recommendations for deciding which patients to refer for investigation of suspected perioperative hypersensitivity reactions

There is variability in the referral patterns for investigation of suspected perioperative allergy, particularly in respect to the referral of minor or cutaneous reactions.

In line with the European Academy of Allergy and Clinical Immunology[1], the Perioperative Allergy Network states the following:

1. Any patient with a suspected hypersensitivity reaction of modified Ring and Messmer grade 1-4 should be referred for investigation, irrespective of the results of mast cell tryptase sampling
2. Patients with transient, self-limiting flushing should not be referred
3. Patients with only localised erythema (e.g. localised to the arm where a drug has been injected) should not be referred

With any referral please include: referral form, copy of anaesthetic chart, brief narrative of the event, current medications, medical history and a suitable non-identifiable photograph of any rash

TABLE 1 Classification of clinical severity of perioperative immediate hypersensitivity: modified Ring and Messmer four-step grading scale[66,67]

Grade I Skin or mucosal signs only • generalized erythema • extensive urticaria • with or without angio-oedema
Grade II Moderate signs from several organ systems • skin or mucosal signs • ± hypotension ± tachycardia • ± bronchospasm • ± gastrointestinal signs
Grade III Life-threatening signs from one or more organ systems • cardiovascular collapse (life-threatening hypotension) • tachycardia or bradycardia ± cardiac dysrhythmia • ± bronchospasm • ± skin or mucosal signs • ± gastrointestinal signs
Grade IV circulatory and/or respiratory arrest

Table 1 taken directly from EAACI position paper[1]

1 – Garvey LH, Ebo DG, Mertes PM, Dewachter P, Garcez T, Kopac P, Laguna JJ, Chiriac AM, Terreehorst I, Voltolini S, Scherer K. An EAACI position paper on the investigation of perioperative immediate hypersensitivity reactions. Allergy. 2019 Oct;74(10):1872-1884. doi: 10.1111/all.13820. Epub 2019 Jun 18. PMID: 30964555.

Association of Anaesthetists CIPN BSACI Improving Allergy Care

Refer any patient with:

- Generalised skin or mucosal signs
- Moderate signs from several organ systems
- Life-threatening signs from 1 or more systems
- Cardio-respiratory arrest

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Specialist allergy referral

- NAP6 tools

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Specialist allergy referral

- Fatal Anaphylaxis Registry (UKFAR)

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ACSA Standard in Perioperative Allergy: GPAS references

- **2.4.16** Anticipated difficulty with anaesthesia should be brought to the attention of the anaesthetist as early as possible before surgery

Peri-operative anaphylaxis

For anaesthetists/intensivists

A = Airway **B** = Breathing **C** = Circulation **D** = Disability **E** = Exposure

Diagnosis – look for:

- Unexplained hypotension, tachycardia, bradycardia, bronchospasm (wheeze may be absent if severe)
- Unexpected cardiorespiratory arrest where other causes are excluded
- Skin signs are often absent in severe reactions

Call for HELP

Stop/remove non-essential surgery. Call for cardiac arrest trolley

Stop/remove suspected triggers if possible

e.g. Antibiotics, NMBAs, dyes, colloids, chlorhexidine coated lines/catheters, lubricants , latex

Give initial IV bolus of adrenaline

Adult and child > 12 years: 50 micrograms IV (0.5 mL IV of 1 mg/10 mL [1:10,000])

Child < 12 years: 1 microgram/kg, needs careful dilution, titrate to effect

If no IV access: 10 micrograms/kg IM, (max 500 micrograms IM) of 1 mg/mL (1:1,000), and secure IV/IO access

If in doubt, give adrenaline

&

Give rapid IV fluid bolus

Adult and child > 12 years: 500–1000 mL

Child < 12 years: 20 mL/kg

- Multiple fluid boluses may be needed (e.g. up to 3-5 L in adults, 60-100 mL/kg in children)
- Avoid colloid

If poor response to adrenaline boluses, start IV infusion*

Involve ICU team early

If systolic BP < 50 mmHg or cardiac arrest, start CPR

A B = Airway/Breathing

Give 100% oxygen Ensure sustained $ETCO_2$ trace. Change to inhalational anaesthetic if appropriate.

Severe/persistent bronchospasm:

- Exclude oesophageal intubation
- Check patent airway and anaesthetic circuit
- Nebulised salbutamol and ipratropium
- Consider IV bronchodilator

C = Circulation

Hypotension may be resistant, requiring prolonged treatment with large volume resuscitation

- Give further fluid boluses, titrate to response
- Consider head-down table-tilt or elevating legs
- Establish invasive monitoring as soon as practical

IF REFRACTORY TO ADRENALINE INFUSION:

- Add a second vasopressor (noradrenaline or vasopressin) **in addition** to adrenaline
- Consider glucagon 1 mg IV in adults on beta-blockers
- Consider steroids for refractory reactions or shock
- Consider extracorporeal life support

Immediate follow-up

- Take blood (clotted) for serum tryptase once stable
- Request further samples 1–4 hours after onset of symptoms, and at least 24 hours later
- Complete allergy referral form: **bit.ly/NAP6referral**
- If surgery is urgent or time-critical and patient is stable, proceed with surgery but avoid suspected triggers
- Refer fatal cases to **bit.ly/UKFAR**

***Use local protocol for adrenaline infusion**

(Peripheral infusion recommended if no central venous access)

OR

Peripheral low-dose IV adrenaline infusion (if no local protocol):

0.5 mg (0.5 mL of 1 mg/mL [1:1000]) in 50 mL

- In both adults and children, start at 0.5–1.0 mL/kg/hour, and **titrate according to clinical response**
- Continuous monitoring and observation is mandatory

Resuscitation Council UK

Association of Anaesthetists

BSACI Improving Allergy Care through education, training and research

British Society for Immunology CIPN Clinical Immunology Professional Network

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Perioperative Allergy Network

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ACSA Standard in Perioperative Allergy: GPAS references

- **2.11.11** …established policy to ensure **clear communication** of continuing requirements at discharge…to include communication **with primary care**…
- *Surgical teams will ordinarily be responsible for most of this process.*

- **Helpnote:** NAP6 tools

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PAN: How can we help you?

- Resources
  - Leaflets
  - Education packages
- Annual seminars
- Become a member

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Questions

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Refreshment Break

Please make your way up to the café
We will return at 11:30am

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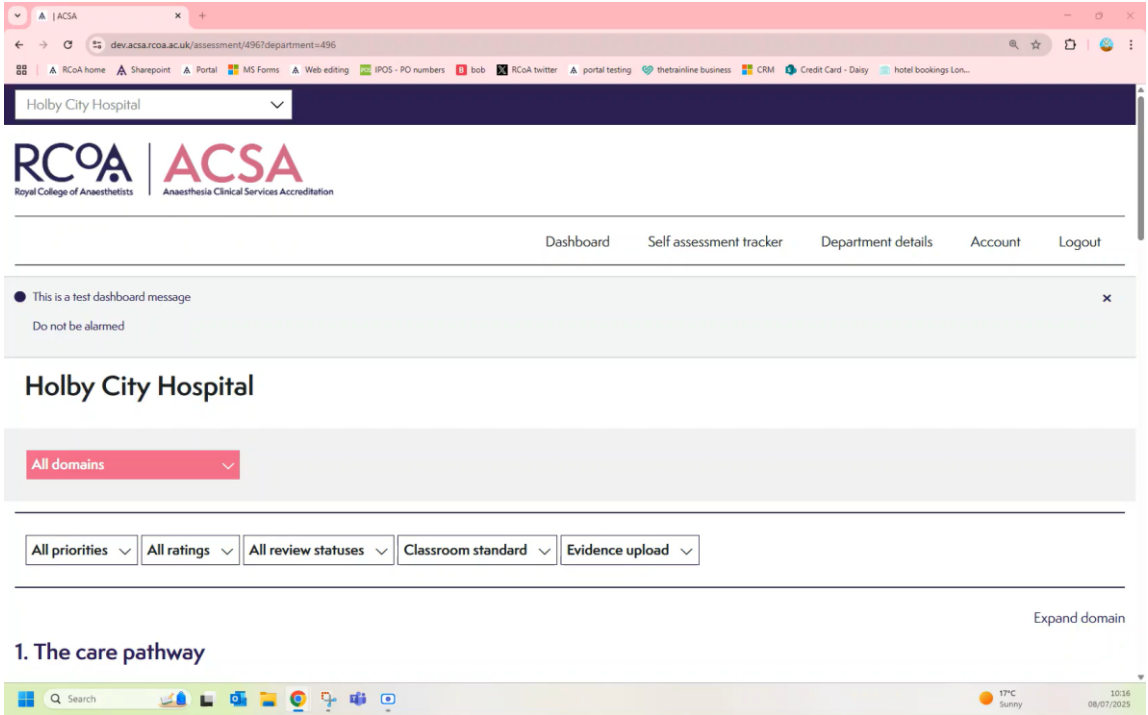
What's New on the Portal

Ruth Nichols, Head of Clinical Quality, RCoA
Wednesday 9 July 2025

Notes



Automatic username and date

All previous notes and evidence since the portal began is transferred over – don't worry!

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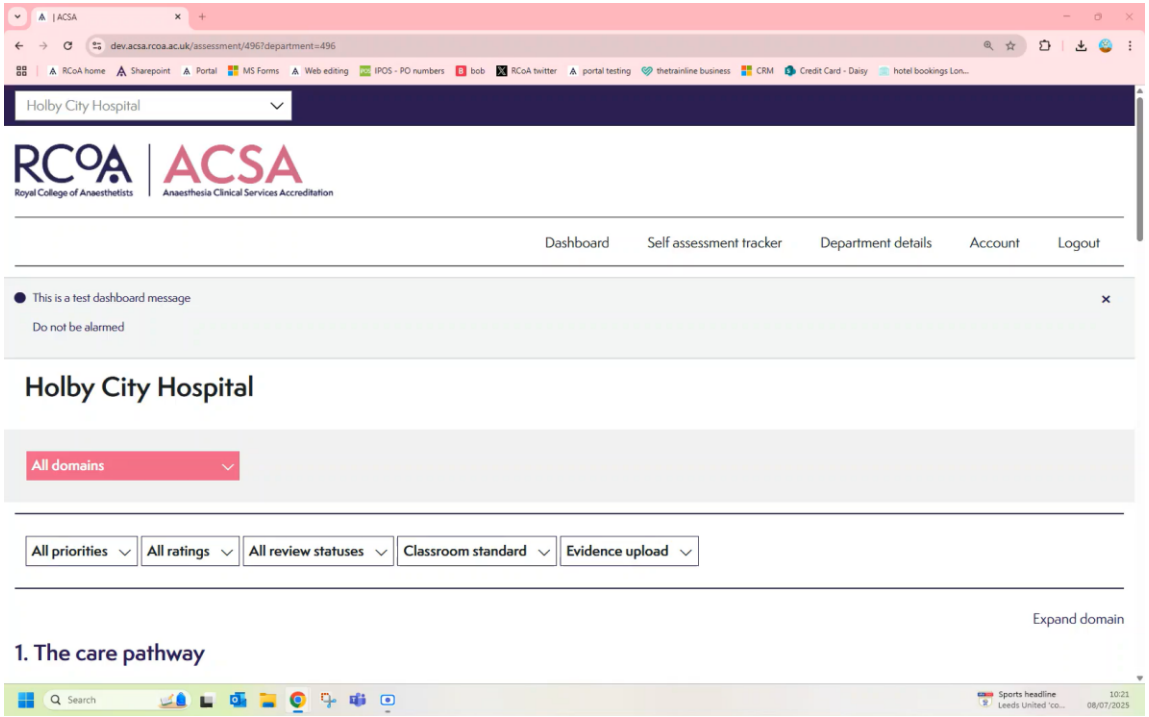
Evidence

Multiple files can be uploaded at one time

Multiple standards can be selected from a drop-down list, per piece of evidence

Evidence bank



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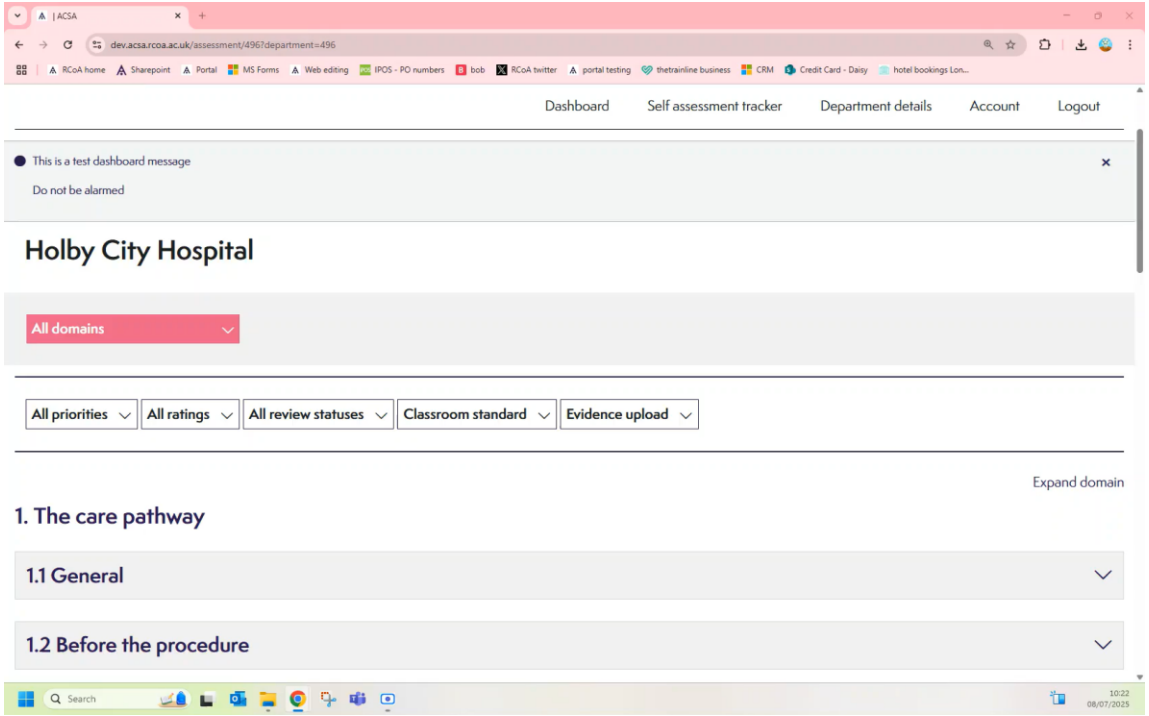
‘Evidence Upload’ filter



Can filter by the date last evidence was uploaded

Helpful to see what other colleagues have uploaded/ where you left off

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Other key changes

- Key announcements from ACSA Team
- Longer title name issue has been resolved
- ACSA team can now see each department's latest activity on the backend

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An AIT's Perspective

Dr Tallulah Boddy
Stage 3 Anaesthetist in Training

10 ANNIVERSARY

es Accreditation

Overview

- My ACSA Journey
- Utilising your AiTs/non consultant grade anaesthetists
- Torbay ACSA Experience
- Tricky standard 3.1.2.2 and Day surgery optimisation

My ACSA Journey

- SIA in Management and Regulatory Bodies
- Trainee ACSA Lead
- Supportive and experienced ES
- Supportive and ‘on board’ department
- ACSA review team member

How did I benefit?

- Broad insight of all aspects of department
- Insight into divisional and organisational structure and roles
- Personal capital within organisation
- Supervision of more junior colleagues
- Management – time, people, meetings
- Policy writing and ratification process

How to utilise your AiTs

- Management SIA
- Senior trainees supervising and delegating to junior trainees
- Policies, QI projects, options appraisals
- ‘trainee lead’ roles
- ACSA ‘Fellowships’ for ‘non training’ positions

Benefits to Department

- Cheaper than consultant PA!
- Integration of trainees into change processes
- Motivated individuals who have recent experience of other trusts
- Individuals who work within other areas of trust
- Creating personnel who are integrated into trust for future substantive roles

Benefits to AiTs

- Broad insights into department and trust
- Leadership
- Meaningful QI
- Personal capital within trust

Torbay's ACSA Journey

- Third accreditation cycle
- Constant re-evaluation
- Momentum – esp. around continued processes (staff training etc.)
- 'On board' department and trust level knowledge/acceptance of process

What has Torbay gained?

- USS provision
- Monitoring updated
- Rest facilities
- DFA
- Theatre alarms
- ODP availability for safe obstetric provision
- Maintained Recognised SPA roles
- Policy updates
- Recovery training

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Torbay Day Surgery

- BADS
- Culture
- Dedicated teams
- Multiskilled nurses
- Emergency DS pathways

Dedicated Teams

- Booking
- Pre Assessment*
- Admission
- Surgery
- Recovery*
- Discharge*
- Follow up*

* Multiskilled nurses

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Tricky Standard

Day surgery

- **3.1.2.2** Day surgery patients are given clear and concise written information on discharge including access to a 24/7 staffed telephone line for advice

Day Surgery Information

- Day surgery handbook at PAC
- Patient specific discharge information through PICIS system + EIDO leaflets
- Copies of their discharge summary
- TTO's and instructions
  - Pre printed (but editable) recovery and TTO prescriptions. Patients are categorised according to expected pain scores for their procedure.

Point of Contact

- **Telephone numbers**
  - In hours: DSU triaged by a nurse. Outcome is usually nurse led advice in about 50% of cases or nurse refers to appropriate specialty - usually the specialty registrar.
  - OOH: General senior nurse bleep holder in the hospital who triages calls e.g. SRU/ED

Day Surgery at Torbay

- All patients called next day
  - Audit and QI
- ‘At home carers’ pathway
- ‘Home alone’ policies

Thank you

- Dr Omar Islam
- Dr Theresa Hinde
- Alex Alen
- TSDFT Anaesthetic Department and Day Surgery Unit
- RCOA ACSA team

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Questions?

Thank you!

Tallulah.boddy@nhs.net

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The Voice of a Lay Reviewer

Mr Stuart Burgess, ACSA Lay Reviewer

The voice of a lay reviewer

- Introduction
- The lay perspective
- How can departments best meet the standards?
- Specific standards – highlighting good practice from my experience
- Patient voices
- Postscript

Royal College of Anaesthetists

Preparing for ACSA

Maria Garside & Dr Sarah Goellner, Bradford Teaching Hospitals NHS Foundation Trust

PREPARING FOR ACSA

Tips, pitfalls and helpful hints

Maria Garside & Simon Cousins

Bradford Teaching Hospitals NHS Foundation Trust

#embeddingkindness

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In a world where you can be anything, be kind

BRADFORD'S EXPERIENCE

- Engaged 2017
- 1st Visit June 2019
- Report Oct 2019
  - Due to complete meeting all standards March 2020
- COVID-19
- Accredited May 2021
- Yearly review process
- 2nd Visit March 2025
- Report July 2025

BENEFITS

- Encourages cohesion across all staff groups and cross-specialty
- Leads to continual improvement and maintenance of high standards
- Recognised by CQC
- For ACSA leads – networking + overall knowledge of services

Theatre staff training

Cell salvage

Local anaesthetic storage

Trust Sedation Committee

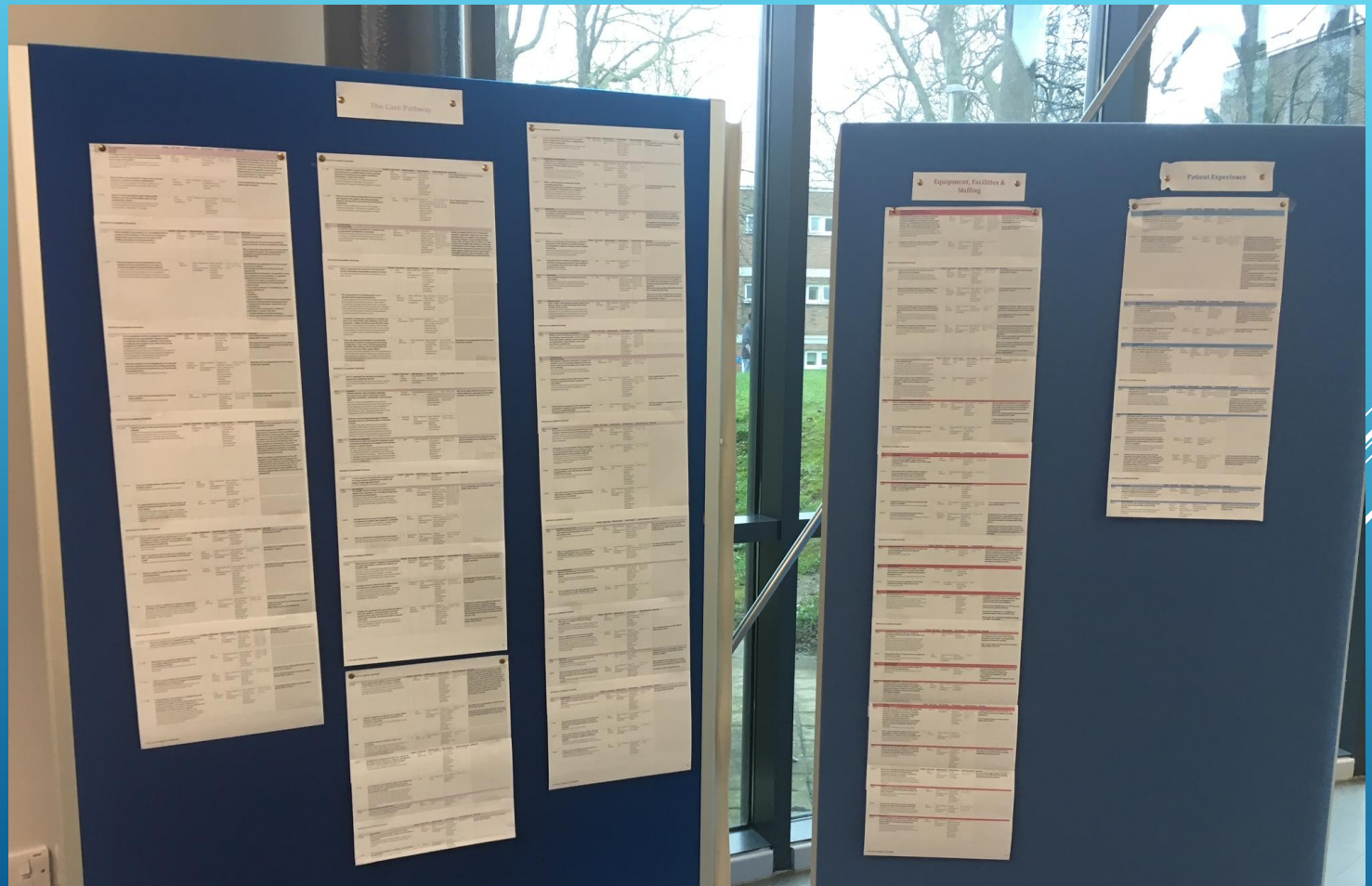
Call bells

TANGIBLE IMPROVEMENTS

It's all about patient care

Get everyone involved

ACSA PRESENTATION DAY – ALL STAFF



TIMELINE

Exec support and departmental involvement
1-3 yrs

Engagement and Self-assessment
1-1.5 yr

Choose date for visit
6-9 months

Completing audits, submitting evidence
6 months

Confirming colleague availability + presentations
4 months

Portal closes
8 weeks

Classroom standards provided
5 weeks

Increasing staff awareness and involvement for visit
4 weeks

Event planning
2-4 weeks

Final preparations
1-2 days

TIMELINE

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Classroom standards provided
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Event planning
2-4 weeks
Final preparations
1-2 days

HELPFUL HINTS

- Start early – it's never too early!!
- Delegate (co-ordinator not lead)
- Bring people on board
- Face to face communication >> short and long term benefits
- Be opportunistic / don't be annoying
- Consider other people's needs and commitments
- Do something everyday


BIG THINGS
HAPPEN
one day
AT A
TIME

Big things happen one day at a time

IMPROVEMENT IN CARE IS MULTIFACTORIAL

- Improved teamworking
- Improved colleague communication
- Improved morale
- Improved multidisciplinary effectiveness

>> All lead to improved efficiency and patient safety

CONSIDER OTHERS

- How does this standard fit in with my colleague's area of work?
- How will this standard help to improve care in their area?
- How will this standard make life better for my colleague?
- How can I help my colleague with what they are trying to achieve?
- Why is this standard important to my colleague?
- Does my colleague have the capacity to consider this now?
- Is there an anaesthetist in training who would benefit from helping to achieve this standard?

My lack of planning does not constitute my colleague's emergency

PITFALLS

Some things take a long time to change (eg LA storage)	• Culture • Equipment
Policies	• Updates • New policies – write, get approved
Gathering + Uploading evidence takes longer than you think!!	• Deciding what to submit • Allow for IT failures
People not being available on the day to meet the review team	• Staff availability

TOP TIPS

- Involve everyone
- Use your college guide early
- Weekly meetings with Manager
- Set your own deadlines – early!
- Expect your colleagues to fail
- Involve trainees – a key asset

TOP TIPS

- Keep a list of audits to hand out
- Collect evidence over the year
- ACSA Fact sheets in final 4 weeks
- Plan the classroom session
- Someone on rooms, food, transport
- Extra people for walkabout session

Check Staff Systems Sessions

FINAL PREP 1-2 DAYS

Staff - people know when and where to meet review team, correct staff available

Systems - IT systems, rooms set up, transport, catering

Sessions - classroom session, walkabout

FINAL PREP 1-2 DAYS

Day one: Wednesday 19th March

09:00– 09:15 Introduction, briefing and housekeeping

This will include an overview of the objectives of the review and the agenda.

09:15 – 10:00 – Presentation

Presentation by the department including a summary of service provision from relevant subspecialty leads.

10:00 – 12:00 Classroom session

The classroom standards identified by the ACSA review team are discussed

CLASSROOM SESSION

30 STANDARDS TO DISCUSS IN DETAIL

Standard	Standard	Staff member
1.7.2.1	**A duty anaesthetist is immediately available for the obstetric unit 24 hours a day. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patient in order to be able to attend immediately to obstetric patients.** The rota should be seen to allow obstetrics to take pricrity where the duty anaesthetist has other responsibilities. A policy should be made available at staff induction regarding prioritising and junior staff should provide verbal confirmation that they have been inducted in this way. Maternity Incentive Scheme (MIS) or equivalent evidence and audits should also be provided.	Al Hughes / S Ali - Obstetric Lead / Department Lead
1.7.2.3	**A system is in place to ensure women requiring antenatal and postnatal anaesthetic referral are seen by an obstetric anaesthetist within an appropriate timeframe.** Verbal confirmation should be given that a system, which staff are satisfied allows enough time, is in place. Women who wish to discuss previous difficult experiences with obstetric anaesthesia and analgesia should be able to do so, even if events were some time in the past.	Al Hughes / S Ali - Obstetric Lead / Department Lead
2.1.1.17	**The department has a plan to address the environmental sustainability of their anaesthetic practice.** There should be a regularly reviewed plan for increasing environmental sustainability in the department. A lead should be named. This does not	K Wilkinson - Sustainability lead

Showcase by Department Leads

rather than a

tick box exercise

CLASSROOM SESSION

1.1.3.2	**Arrangements are in place for the multidisciplinary management of frail patients.** A copy of the policy should be provided. Such a policy should include the involvement of physicians and a formal system for assessing and recording frailty and the cognitive status of patients during preoperative assessment.

Bradford Teaching Hospitals NHS
NHS Foundation Trust

GUIDELINES FOR PRE-OPERATIVE ASSESSMENT of ADULTS

Author (name and designation):	Samantha Kritzinger (Consultant Anaesthetist)
Version Number:	
Approval Committees:	
Ratified by:	
Date ratified:	
Date issued:	2025
Review date:	2030

REFERRAL CRITERIA FOR CONSULTANT ANAESTHETIST PRE-ASSESSMENT CLINIC APPOINTMENT

Referrals by formal letter or email to preassessment.SLH@bthft.nhs.uk or EPR from another medical professional (consultant/ACP/Senior trainee)

	Consultant Anaesthetic assessment	Anaesthetic review of notes or discussion with anaesthetist +/- decision to recall patient for face-to-face assessment
All patients for major complex surgical cases are to be reviewed routinely by a Consultant Anaesthetist *Routine CPET test **CPET test may be considered, but not routine	• Aortic surgery* • Major colorectal surgery – laparoscopy and laparotomy • Major urology o Cystectomy* o Cysto-prostatectomy* o *any* ileal conduit formation** o nephrectomy • Major upper GI surgery o Oesophagectomy* o Gastrectomy* o Whipple's procedure* o Weight reduction surgery • Major complex orthopaedic surgery o revision hip or knee replacement in ASA III or more patients • Major head and neck surgery o complex resections and reconstructive surgery	
Patients with previous anaesthetic related complications		• Difficult intubation or previous awake fibre-optic intubation (anticipated or documented) • Family history of serious anaesthetic problems o malignant hyperthermia o suxamethonium apnoea o porphyria • Anaphylaxis • History of major anaesthetic complication
Patients with cardiac conditions	• Pulmonary Hypertension • Cardiac failure o Not optimally controlled o Documented moderate to severe left ventricular impairment o Pacemaker for cardiac resynchronisation therapy o Dyspnoea at rest or on minimal exertion • Valve lesions o Known, suspected or symptomatic moderate/severe aortic stenosis or mitral stenosis	• Mitral or aortic valve replacement • Patients who have had coronary angioplasty with/without stents within the last 12 months • Patients on dual antiplatelet agents with cardiac stents • New/undiagnosed murmur – for discussion with possible need for Echocardiogram • Patients with functional impairment due to other valve or congenital heart disease • Pre-assessment ECG with Mobitz II block, complete heart block, tri-fascicular block • Uncontrolled or symptomatic arrhythmias (e.g. SVT/AF/Atrial Flutter) • **Patients with valve replacements who are anticoagulated** • Acute myocardial infarction within last 6 months • Follow guidelines for poorly controlled or uncontrolled hypertension
Patients with respiratory conditions	• Pulmonary Hypertension • Brittle asthmatic patients – hospital admissions in the last 12 months or ICU admissions in the past • Severe emphysema or COPD – limited functional capacity (dyspnoea at rest or minimal exertion), frequent respiratory tract infections requiring antibiotics and steroids, frequent hospital admissions or ICU admission in the past • Patients on home oxygen • Any other incapacitating respiratory symptoms	• Obstructive Sleep Apnoea (OSA) o Any patient screened for OSA in pre-assessment centre or elsewhere scoring ≥ 6/8 on STOPBANG criteria o Any patient with OSA on CPAP
Other conditions	• **Renal** o Patients on renal dialysis for end stage renal failure o Patients with chronic kidney disease stage 4/5 with Cr > 170 mmol/L • **Frailty** Any patient with CFS of >5 requiring major surgery • **Neuromuscular** o Muscular dystrophies o Myasthenia gravis • Severe rheumatoid arthritis or ankylosing spondylitis affecting mouth opening or neck extension • **Haematological** o Jehovah's witness for major surgery o Haemoglobinopathies o Acquired or hereditary thrombophilia or haemophilia	• Patients with poorly controlled diabetes (HbA_{1c} ≥75mmol/mol) • Abnormal thyroid function tests • Abnormal urea & electrolytes o Na^+ < 125mmol/L o K^+ > 6mmol/L o Ca^{2+} > 3mmol/L o Creatinine 110 – 170 micromol/L • Central Nervous System o CVA/TIA within the last 3 months • Anaemia (in context of patient undergoing major surgery where anticipated blood loss above 500ml) (see Anaemia pathway) • Patients on anticoagulation or antiplatelet agents • Elevated BMI or very high body weight

SUMMARY

Remember - it's all about lasting safety and quality improvement

Involve everyone

Do something everyday

Be opportunistic

Use the good practice library / college guide

Don't be surprised when people let you down

Everything takes longer, so give yourself extra time at every stage

Plan to have lots of extra people available for the visit

It's all about patient care

Get everyone involved

Maria.Garside@bthft.nhs.uk

9th July 2025

Trainees: A key asset in ACSA preparation

Dr Sarah Goellner

Anaesthetic Registrar ST6
Bradford Teaching Hospitals NHS Foundation Trust

NHS
Bradford Teaching Hospitals
NHS Foundation Trust

Key takeaways for trainee involvement in the ACSA process

- Creates significant **efficiencies** in the ACSA process
- Engages trainees with the department and team — trainees feel **part of the department**
- Helps trainees meet training **curriculum standards**
- Currently, trainee involvement is not a formal requirement of ACSA

Outline

01 How we engaged trainees

02 Examples

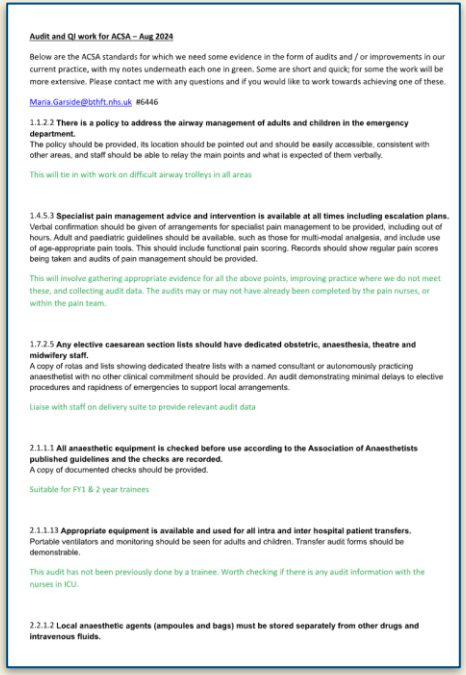
03 Benefits

Engaging trainees (how)

Formalising the process of recruiting trainees increases buy-in

Timeline: Aug 2024 – Mar 2025

- Make a **formal request** with a clear scope – not just a casual ask
- Be upfront about what's involved to **align expectations**
- Give **autonomy** with the right balance of support (avoid the "job monkey" feeling)
- A **trainee lead/champion** was key to engagement
- Use a WhatsApp group for **coordination**



Audit and QI work for ACSA – Aug 2024

Below are the ACSA standards for which we need some evidence in the form of audits and / or improvements in our current practice, with my notes underneath each one in green. Some are short and quick; for some the work will be more extensive. Please contact me with any questions and if you would like to work towards achieving one of these.

Maria.Garside@bthft.nhs.uk #6446

1.1.2.2 **There is a policy to address the airway management of adults and children in the emergency department.**
The policy should be provided, its location should be pointed out and should be easily accessible, consistent with other areas, and staff should be able to relay the main points and what is expected of them verbally.

This will tie in with work on difficult airway trolleys in all areas

1.4.5.3 **Specialist pain management advice and intervention is available at all times including escalation plans.** Verbal confirmation should be given of arrangements for specialist pain management to be provided, including out of hours. Adult and paediatric guidelines should be available, such as those for multi-modal analgesia, and include use of age-appropriate pain tools. This should include functional pain scoring. Records should show regular pain scores being taken and audits of pain management should be provided.

This will involve gathering appropriate evidence for all the above points, improving practice where we do not meet these, and collecting audit data. The audits may or may not have already been completed by the pain nurses, or within the pain team.

1.7.2.5 **Any elective caesarean section lists should have dedicated obstetric, anaesthesia, theatre and midwifery staff.**
A copy of rotas and lists showing dedicated theatre lists with a named consultant or autonomously practicing anaesthetist with no other clinical commitment should be provided. An audit demonstrating minimal delays to elective procedures and rapidness of emergencies to support local arrangements.

Liaise with staff on delivery suite to provide relevant audit data

2.1.1.1 **All anaesthetic equipment is checked before use according to the Association of Anaesthetists published guidelines and the checks are recorded.**
A copy of documented checks should be provided.

Suitable for FY1 & 2 year trainees

2.1.1.13 **Appropriate equipment is available and used for all intra and inter hospital patient transfers.**
Portable ventilators and monitoring should be seen for adults and children. Transfer audit forms should be demonstrable.

This audit has not been previously done by a trainee. Worth checking if there is any audit information with the nurses in ICU.

2.2.1.2 **Local anaesthetic agents (ampoules and bags) must be stored separately from other drugs and intravenous fluids.**

We had 7 trainees involved..

2 Co-leads (ST6/ST7)

5 AiTs (FY1-ST5)

2 Consultants

1. Education & Teaching

- Simulation teaching
- Weekly teaching
- Tea Trolley sessions
- Wellbeing

2. Resources & Information

- Obstetric information sheets
- Red emergency folders
- ACSA awareness posters/fact sheets

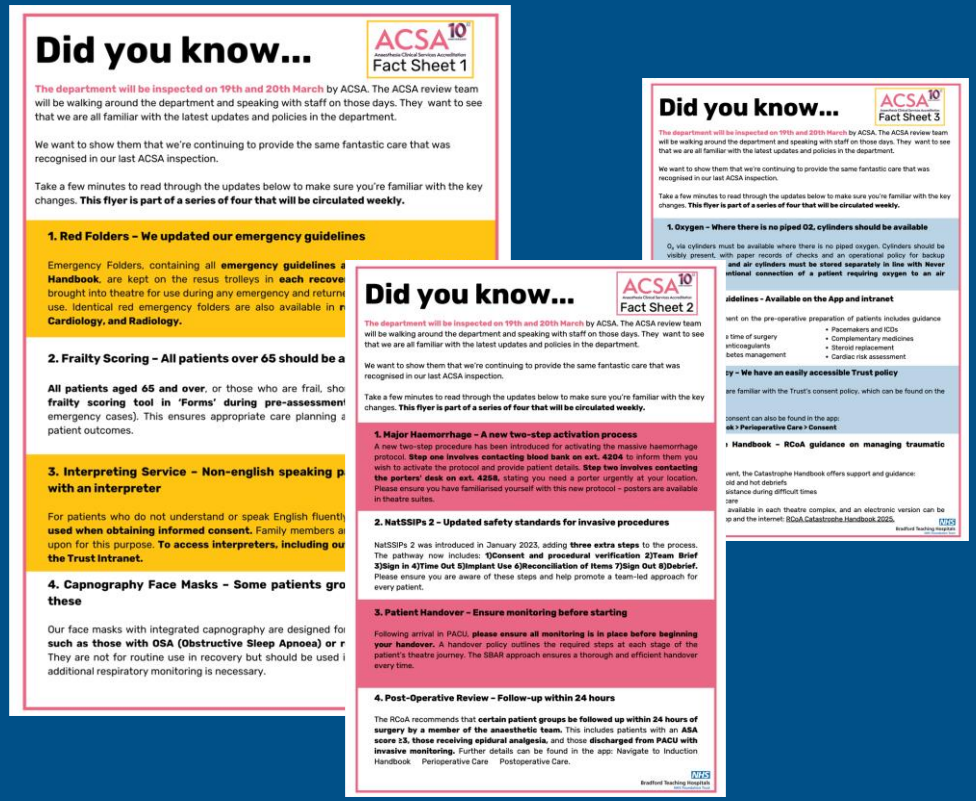
3. Governance & Safety

- SOP reviews
- LA (local anaesthetic) storage checks/updates

Practical examples (what)

1. Tea trolley teaching & ACSA fact sheets

Raised staff awareness prior to visit



Did you know...

ACSA 10 Fact Sheet 1

The department will be inspected on 19th and 20th March by ACSA. The ACSA review team will be walking around the department and speaking with staff on those days. They want to see that we are all familiar with the latest updates and policies in the department.

We want to show them that we're continuing to provide the same fantastic care that was recognised in our last ACSA inspection.

Take a few minutes to read through the updates below to make sure you're familiar with the key changes. **This flyer is part of a series of four that will be circulated weekly.**

1. Red Folders – We updated our emergency guidelines

Emergency Folders, containing all **emergency guidelines a Handbook**, are kept on the resus trolleys in **each recove** brought into theatre for use during any emergency and returne use. Identical red emergency folders are also available in n **Cardiology, and Radiology.**

2. Frailty Scoring – All patients over 65 should be a

All patients aged 65 and over, or those who are frail, sho **frailty scoring tool in 'Forms' during pre-assessmen** emergency cases). This ensures appropriate care planning a patient outcomes.

3. Interpreting Service – Non-english speaking p with an interpreter

For patients who do not understand or speak English fluentl **used when obtaining informed consent.** Family members a upon for this purpose. **To access interpreters, including ou the Trust Intranet.**

4. Capnography Face Masks – Some patients gro these

Our face masks with integrated capnography are designed fo **such as those with OSA (Obstructive Sleep Apnoea) or r** They are not for routine use in recovery but should be used i additional respiratory monitoring is necessary.

Did you know...

ACSA 10 Fact Sheet 2

The department will be inspected on 19th and 20th March by ACSA. The ACSA review team will be walking around the department and speaking with staff on those days. They want to see that we are all familiar with the latest updates and policies in the department.

We want to show them that we're continuing to provide the same fantastic care that was recognised in our last ACSA inspection.

Take a few minutes to read through the updates below to make sure you're familiar with the key changes. **This flyer is part of a series of four that will be circulated weekly.**

1. Major Haemorrhage – A new two-step activation process

A new two-step procedure has been introduced for activating the massive haemorrhage protocol. **Step one involves contacting blood bank on ext. 4204** to inform them you wish to activate the protocol and provide patient details. **Step two involves contacting the porters' desk on ext. 4258,** stating you need a porter urgently at your location. Please ensure you have familiarised yourself with this new protocol – posters are available in theatre suites.

2. NatSSIPs 2 – Updated safety standards for invasive procedures

NatSSIPs 2 was introduced in January 2023, adding **three extra steps** to the process. The pathway now includes: **1)Consent and procedural verification 2)Team Brief 3)Sign in 4)Time Out 5)Implant Use 6)Reconciliation of Items 7)Sign Out 8)Debrief.** Please ensure you are aware of these steps and help promote a team-led approach for every patient.

3. Patient Handover – Ensure monitoring before starting

Following arrival in PACU, **please ensure all monitoring is in place before beginning your handover.** A handover policy outlines the required steps at each stage of the patient's theatre journey. The SBAR approach ensures a thorough and efficient handover every time.

4. Post-Operative Review – Follow-up within 24 hours

The RCoA recommends that **certain patient groups be followed up within 24 hours of surgery by a member of the anaesthetic team.** This includes patients with an **ASA score ≥3, those receiving epidural analgesia,** and those **discharged from PACU with invasive monitoring.** Further details can be found in the app: Navigate to Induction Handbook Perioperative Care Postoperative Care.

Bradford Teaching Hospitals

Did you know...

ACSA 10 Fact Sheet 3

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We want to show them that we're continuing to provide the same fantastic care that was recognised in our last ACSA inspection.

Take a few minutes to read through the updates below to make sure you're familiar with the key changes. **This flyer is part of a series of four that will be circulated weekly.**

1. Oxygen – Where there is no piped O2, cylinders should be available

O_2 via cylinders must be available where there is no piped oxygen. Cylinders should be visibly present, with paper records of checks and an operational policy for backup **and air cylinders must be stored separately in line with Never onal connection of a patient requiring oxygen to an air**

idelines - Available on the App and intranet

ent on the pre-operative preparation of patients includes guidance

- Pacemakers and ICDs
- Complementary medicines
- Steroid replacement
- Cardiac risk assessment

e time of surgery
ntticoagulants
betes management

y – We have an easily accessible Trust policy

re familiar with the Trust's consent policy, which can be found on the

consent can also be found in the app:
ok > Perioperative Care > Consent

Handbook – RCoA guidance on managing traumatic

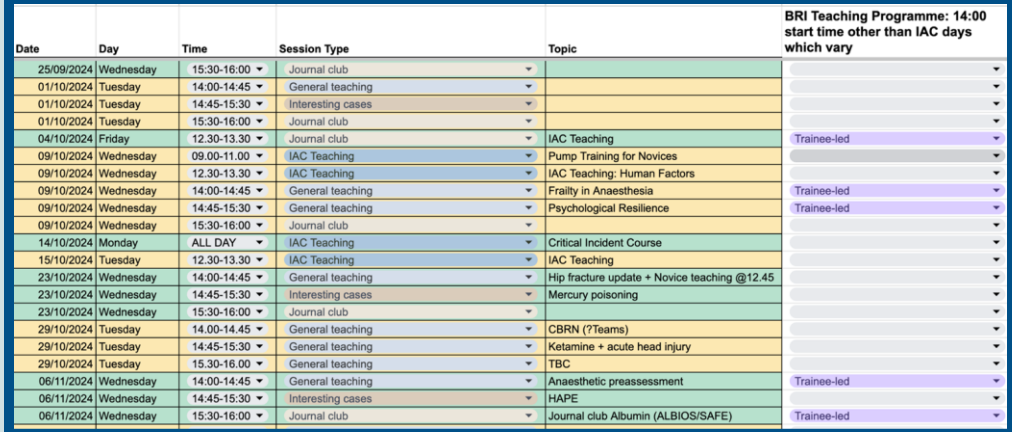
vent, the Catastrophe Handbook offers support and guidance:
old and hot debriefs
sistance during difficult times
are
available in each theatre complex, and an electronic version can be
p and the internet: RCoA Catastrophe Handbook 2025.

Bradford Teaching Hospitals

NHS Bradford Teaching Hospitals NHS Foundation Trust

2. Clinical teaching and simulation

Aligned directly with ACSA Continuous Professional Development standards



Date	Day	Time	Session Type	Topic	BRI Teaching Programme: 14:00 start time other than IAC days which vary
25/09/2024	Wednesday	15:30-16:00	Journal club		
01/10/2024	Tuesday	14:00-14:45	General teaching		
01/10/2024	Tuesday	14:45-15:30	Interesting cases		
01/10/2024	Tuesday	15:30-16:00	Journal club		
04/10/2024	Friday	12.30-13.30	Journal club	IAC Teaching	Trainee-led
09/10/2024	Wednesday	09.00-11.00	IAC Teaching	Pump Training for Novices	
09/10/2024	Wednesday	12.30-13.30	IAC Teaching	IAC Teaching: Human Factors	
09/10/2024	Wednesday	14:00-14:45	General teaching	Frailty in Anaesthesia	Trainee-led
09/10/2024	Wednesday	14:45-15:30	General teaching	Psychological Resilience	Trainee-led
09/10/2024	Wednesday	15:30-16:00	Journal club		
14/10/2024	Monday	ALL DAY	IAC Teaching	Critical Incident Course	
15/10/2024	Tuesday	12.30-13.30	IAC Teaching	IAC Teaching	
23/10/2024	Wednesday	14:00-14:45	General teaching	Hip fracture update + Novice teaching @12.45	
23/10/2024	Wednesday	14:45-15:30	Interesting cases	Mercury poisoning	
23/10/2024	Wednesday	15:30-16:00	Journal club		
29/10/2024	Tuesday	14.00-14.45	General teaching	CBRN (?Teams)	
29/10/2024	Tuesday	14:45-15:30	General teaching	Ketamine + acute head injury	
29/10/2024	Tuesday	15.30-16.00	General teaching	TBC	
06/11/2024	Wednesday	14:00-14:45	General teaching	Anaesthetic preassessment	Trainee-led
06/11/2024	Wednesday	14:45-15:30	Interesting cases	HAPE	
06/11/2024	Wednesday	15:30-16:00	Journal club	Journal club Albumin (ALBIOS/SAFE)	Trainee-led

STANDARD 2.5.6.2
"There is regular multidisciplinary team based training for emergency situations."

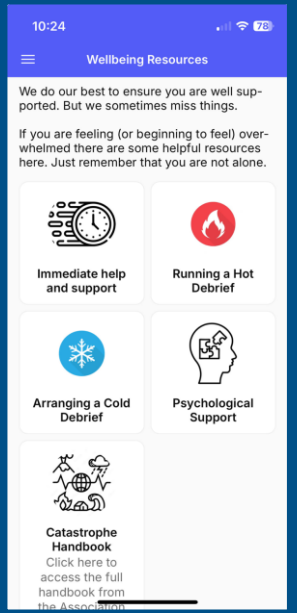
STANDARD 1.1.1.8
"There are clear escalation processes should emergencies occur simultaneously."

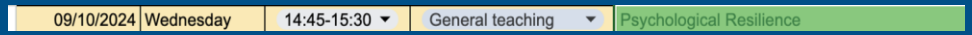
STANDARD 4.3.3.1
"All members of staff should receive adequate time, resources and support for all activities related to appraisal and revalidation, including access to continued professional development."

STANDARD 4.2.2.1
"The department has a managed process of audit and quality improvement which includes regular presentation and information sharing of demonstrated learning and improvement planning."

3. Championing wellbeing

Aligned directly with ACSA culture standards





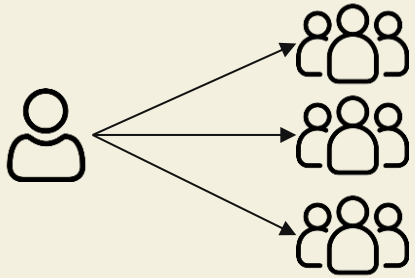
STANDARD 4.1.3.1
"The department promotes the health and wellbeing of staff members."

STANDARD 4.2.1.4
"There is a process in place to ensure a team debriefing takes place after a patient death in the operating theatre suite or significant critical incident and a policy which appropriately addresses the pastoral care of staff members involved."

Benefits (why)

Trainee involvement has benefits for both the department and trainees

Increases **efficiency**



Fosters **trainee-department relationship**

Aligns with **trainee curriculum**

ACSA involvement helps meet multiple curriculum domains

Mapped experience to 2021 RCoA Curriculum Non-Clinical Domains:

Professional Behaviours and Communication
Management and Professional and Regulatory Requirements
Team Working
Safety and Quality Improvement
Safeguarding
Education and Training
Research and Managing Data
Perioperative Medicine and Health Promotion
General Anaesthesia
Regional Anaesthesia
Resuscitation and Transfer
Procedural Sedation
Pain
Intensive Care

ACSA involvement helps meet multiple curriculum domains

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Regional Anaesthesia
Resuscitation and Transfer
Procedural Sedation
Pain
Intensive Care

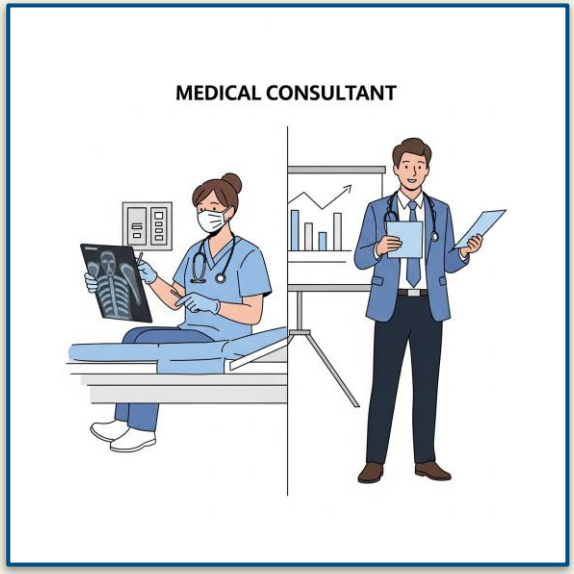
It provided real-world experience for consultant life

ACSA involvement was an excellent trial run for future consultant responsibilities

Exposure to **non-clinical responsibilities**

Communication across the **MDT**

Leadership and management skills



A formal ACSA role would help facilitate trainee involvement..

- **Formalises** the process of trainee recruitment
- Gives trainees **autonomy** and **buy-in**
- Acknowledges **time commitment and effort**

Thank you

Royal College of Anaesthetists

Lunch Break

We will return at 13:45pm

Tricky Standards Workshop

For each scenario, think about these questions:

- Is the evidence sufficient? Is there anything else you'd like to see?
- Is there anything that stands out for you? (good or bad)
- How does this compare to practice at your hospital?
- How would you rate this standard?
  - (Met / Met with recommendations / Not met)

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Scenario 1: How would you rate this standard?

Scenario 2: How would you rate this standard?

Scenario 3: How would you rate this standard?

Scenario 4: How would you rate this standard?

Scenario 5: How would you rate this standard?

Royal College of Anaesthetists

ACSA Panel Discussion and Open Forum

Audience Q&A

Closing Comments

- **Feedback survey** to be sent via email
- **CPD certificate** and links to **recordings** to follow within the next 10 working days
- Please drop **badge passes** & **lanyards** off at reception

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Audience Q&A

Audience Q&A