

NOVEMBER 2020

Bulletin

The magazine for members of the Royal College of Anaesthetists

Remote pre-assessment for
cancer surgery during the
COVID-19 pandemic

Transforming paediatric major
trauma care

Simulation training – 'It's just like
flying a plane'



Research issue:
The challenges COVID-19 has
placed on the research community

RCoA Events

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NOVEMBER

RCoA and RA-UK joint webinar:
blocks for the many (not just the few)
10 November 2020
Evening webinar

Clinical Directors Network
Meeting
16 November 2020
Virtual event

Leadership and Management: Working well in teams and making an impact
18 November 2020
RCoA, London

Anaesthetic Updates
19 November 2020
Virtual event

Anaesthetists as Educators: Anaesthetists' Non Technical Skills (ANTS)
20 November 2020
Virtual event

Anaesthesia Research
24 November
Virtual event

RCoA and BJA joint webinar:
how BJA Editors decide which papers to publish
24 November 2020
Evening webinar

Developing World Anaesthesia
November 2020
Virtual event

Airway Workshop
November 2020
Virtual event

DECEMBER

Winter Symposium
3–4 December 2020
Virtual event

Less than full time (LTFT) matters webinar
9 December 2020
Virtual event

Primary FRCA Online Revision Course
December 2020 – February 2021
Virtual event

Final FRCA Online Revision Course
December 2020 – March 2021
Virtual event

JANUARY

GASAgain (Giving Anaesthesia Safely Again)
13 January 2021
Bradford

Anaesthetists as Educators: Advanced Educational Supervision
26 January 2021
Birmingham

Anaesthetic Updates
29 January 2021
Southampton

FEBRUARY

Presentation of Diplomates Ceremony
1 February 2021
Central Hall, London
Invitation only

AaE: teaching and training in the workplace
2–3 February 2021
RCoA, London
FULLY BOOKED

Innovations and interlectual property conference
3 February 2021
RCoA, London

Anaesthetic updates
24–26 February 2021
RCoA, London

MARCH

Airway workshop
1 March 2021
To be confirmed

Anaesthetic updates
4 March 2021
Bristol

AaE: Introduction
11 March 2021
FULLY BOOKED

Developing World Anaesthesia
15 March 2021
RCoA, London

Global Anaesthesia
16 March 2021
RCoA, London

Leadership and management: The Essentials
16–17 March 2021
Glasgow

Leadership and management: Personal Effectiveness
26 March 2021
RCoA, London

Ultrasound Workshop
29 March 2021
RCoA, London

Anaesthetic updates
March 2021
RCoA, London

APRIL

After the Final FRCA
21 April 2021
RCoA, London

Cardiac Symposium
22–23 April 2021
RCoA, London

AaE: Teaching and training in the workplace
28–29 April 2021
Edinburgh

EVENTS AND COVID-19

Due to the ongoing COVID-19 situation we have moved the majority of our events on to virtual platforms, where this is not possible some of these events may be postponed or cancelled.

Please keep up to date by visiting our webpage:
rcoa.ac.uk/events

AaE: Advanced Educational Supervision

26 January 2021
Birmingham



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

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From the editor

Dr Helgi Johannsson

Welcome to the November Bulletin.

As you open your November edition of the *Bulletin*, I sincerely hope we have managed to prevent a large second wave of coronavirus infection. But as I write we are finally seeing the increase in cases predicted of a second wave. Still, in my hospital there are no patients with coronavirus on the intensive care unit, which gives me some hope that we may be able to continue with the enormous task of getting the NHS's elective work back on track and reversing the colossal disruption that has affected all our lives.

COVID-19 has dominated the news and our conversations, and so it is no surprise that this month's edition of the *Bulletin* contains a lot of pandemic-related articles. It's not all bad news however, and the articles on pre-assessment show how the pandemic has focused our minds and streamlined so many pathways. In order to access an operation, a patient may previously have had to attend several face-to-face appointments at different times, many of which now occur remotely and at the mutual convenience of patient and clinician. It is also wonderful to see the empowerment of nursing staff taking on extra roles, and the innovative use of technology. I personally found the tips on remote meetings very useful and hope that incorporating them will avoid humiliating technical glitches happening at awkward moments – as we have all witnessed on TV and radio just as the person being interviewed is coming to the crucial point of the whole interview.

This month we showcase research in anaesthesia, and I am delighted to see that, after the first wave, research activity is up and running again. The topics covered are as important as ever – COVID-19 cannot be allowed to stop our progress as a specialty. The same applies to education, where the article on remote simulation shows that it can be done.

Your representatives – the College Council members – feature again in this edition, where Dr Kirstin May reflects on where we have come, and how SAS-grade doctors have not only been indispensable in the response to COVID-19, but still are as we try to get elective work back on track. In our 'As we were' article we hear from Janice Fazackerley, our previous vice-president. Throughout her tenure she was a sensible voice of reason with a passion for the doctors and patients she represented. She will be much missed from Council, but I'm pleased to say that she very much remains a friend and a source of excellent advice.

Finally, I want to extend my gratitude to Lyndsey Forbes for the moving and highly personal account of her experience of obesity and weight-loss surgery. What we say in the coffee-room and see as mere 'banter' can hurt. We may forget what was said, but we will never forget how it made us feel.

Here's hoping we'll be able to spend Christmas in groups larger than six!



The President's View

RESEARCH AND COVID-19



Professor Ravi Mahajan
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Professor Iain Moppett
Deputy Director, Health Services
Research Centre

The COVID-19 pandemic has had significant impacts on research. Some have been positive, while some are causing short-term and possibly longer-term problems. Now is a good time to take stock of where anaesthesia and critical care research is and how it is placed to face challenges going forward.

When the pandemic hit, most clinical research was halted or restricted to activities that were essential to maintain participant safety or the integrity of the studies. Research-active clinicians and research support teams across the country shifted their work patterns to support their local clinical services. Inevitably this has delayed development, recruitment, analysis and publication of research projects, but with the easing of 'surge' rotas, colleagues are starting to catch up. There is a double-hit of reduced and variable clinical work impacting on the ability of studies to recruit in a timely fashion.

The limitations on face-to-face working have changed the nature of research, from the laboratory through to large clinical trials. Universities have the same requirements for COVID-safe working environments as other businesses, and it is not clear exactly how social distancing requirements will impact on traditionally close-working environments such as laboratories. It is almost certain to increase costs. Teleconferencing is the new normal for research groups, but only time will tell how much the social and academic interactions within and between research groups in coffee rooms, seminars, and conferences will affect future research. On

the other hand, some researchers are highlighting the benefits of enforced virtual meetings, with less travel time and fewer barriers to collaborations with geographically dispersed colleagues.

In addition to the changes it has prompted in clinical practice, COVID-19 has given a kick to some perhaps overdue changes in research practice. Virtual/telephone consent and follow-up is becoming much more the norm alongside electronic data capture.

The pandemic has highlighted an undoubted strength of the NHS research infrastructure and culture. Landmark studies such as RECOVERY (Randomised evaluation of COVID-19 therapy) and REMAP-CAP (Randomised, embedded, multifactorial, adaptive platform trial for community-acquired pneumonia) would not be possible without a national research infrastructure. Nor would they happen without the willingness of clinicians to enrol and care for patients within randomised controlled trials. The importance of clinicians supporting patients' participation in trials when there is scientific equipoise, regardless of their own personal views, cannot be overstated. Prior to RECOVERY, many clinicians may have held strong views for or

against the use of steroids, but only by recruiting to the trial do we have the answers. It would be good to see this approach spill over and continue in future non-COVID research.

However, the situation moving forward remains uncertain. Funding of research projects is likely to become more difficult. Social distancing effects may increase laboratory costs. Major funders such as the National Institute for Health Research will be hit by the costs of overrunning studies, not to mention the wider economic impact of COVID. Universities are facing significant shortfalls in the coming years due to loss of income from teaching, hospitality and research. The opportunities to replace or appoint staff are likely to be few and far between. Universities are under pressure to deliver high-quality online and virtual teaching to more medical students than ever before. Inevitably, university-employed clinical academics will be asked to provide more support to these important roles.

Early exposure to research is vital to a healthy and continuing research

Only by recruiting to studies will we find the answers to important clinical questions.

community. NHS and university clinicians and researchers have for a long time contributed to this exposure through medical student projects. The College, alongside the Association of Anaesthetists, *BJA Anaesthesia*, and the Neuroanaesthesia and Critical Care Society, provides competitive financial support through the John Snow Intercalated Award. Many of these smaller projects have been laboratory-based or volunteer-based work. There may need to be a reimagining of how such projects will work in the future.

High-quality-data science research may play an increasing role in the future. The NHS – as well as Health Services Research Centre projects such as the National Emergency Laparotomy Audit (NELA) and Perioperative Quality Improvement Programme (PQIP) – provide high-quality, routinely collected

data that can provide answers to some of the questions about how safe and effective care can or should be delivered. This isn't to say that high-quality randomised controlled trials are not important. We are delighted to report that the first Perioperative Medicine Clinical Trials Network (POMCTN) led trial (Volatile vs total intravenous anaesthesia for major non-cardiac surgery [VITAL] trial, led by POMCTN Deputy Director, Dr Joyce Yeung) has been funded (£1.4 million) by the NIHR Health Technology Assessment programme. VITAL will be comparing patient outcome between inhalational and total intravenous anaesthesia and is a data-enabled trial which will use the existing PQIP infrastructure.

It will not have escaped the notice of College members that an awful lot of COVID-related 'research' has been

put into the public domain, whether on social media, or as pre-prints or peer-reviewed publications. Sadly, but not unpredictably, much of this 'research' has not withstood scrutiny. Game-changing claims have been quietly forgotten, and even the major journals have had to retract papers. We are fortunate that the anaesthesia and critical care community has articulate and well-respected researchers who have been able to offer context and critique for both the clinician and the wider public. Dr Charlotte Summers from Cambridge has won praise for her ability to explain complex and sensitive topics in an engaging and informative way.

It would be remiss not to mention some of the work that anaesthetists in training and fellows have somehow managed to pull out of the bag at the height of COVID. Hopefully many members will have contributed to IntubateCOVID (Dr Danny Wong), reflected on the early analysis of deaths in healthcare workers (Dr Emira Kursomovic), and digested the systematic review of ICU outcomes following COVID (Dr Richard Armstrong and Dr Andrew Kane).

COVID-19 has brought many challenges to the research community, with many more to follow. Anaesthesia and critical care research are well placed to meet these, but will be working in an increasingly constrained and competitive environment. Above all, we could not be delivering research for the benefit of our patients and colleagues without the continuing support of our members.

If you have any comments or questions about any of the issues discussed in this President's View, or would like to express your views on any other subject, I would like to hear from you. Please contact me via presidentnews@rcoa.ac.uk

Turn to page 29 to read more about how the Health Services Research Centre's (HSRC) work has been affected by the pandemic in their 2020 Annual Report.

Bulletin

of the Royal College of Anaesthetists

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Articles for submission, together with any declaration of interest, should be sent to the Editor via email to bulletin@rcoa.ac.uk

All contributions will receive an acknowledgement and the Editor reserves the right to edit articles for reasons of space or clarity.

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NEWS IN BRIEF

News and information from around the College

Council Election

Don't forget to vote in the election to Council, where you'll be choosing your representatives for one Consultant place and one SAS place. Ballots will be sent by email on 16 November and voting will close on 14 December. Council members play a hugely important role in the working life of the College and in advocating for all our members, so do get your vote in.

Those eligible to vote are:

- Fellows (apart from Honorary Fellows), Members, Associate Members, Trainees and Senior Fellows and Members for the Consultant vacancy
- Members and Associate Members for the SAS vacancy
- If your membership fits one of these categories and after 16 November you haven't received a ballot email, please contact ceo@rcoa.ac.uk, including your college reference number.



Scottish Board Election

Nominations for places on the RCoA Scottish Board open on 4 November. Put your name forward before the closing date of 2 December for the chance to join a board of colleagues who meet three times a year to provide an important link between the College and Fellows and Members based in Scotland.

Further information can be found on the College website and you can discuss the opportunities in more detail with the current chair, Dr Sarah Ramsay (sramsay@rcoa.ac.uk)

Translations of patient information leaflets

The College is working in partnership with the international translation charity Translators without Borders to provide translations of our most popular patient information leaflets in the 20 most common languages used in the UK, including Welsh.

You and your anaesthetic, Your spinal anaesthetic and Your child's general anaesthetic are now available in the current selection of translations. Soon to follow – Anaesthetic choices for hip or knee replacement.

Please see our website for further details: rcoa.ac.uk/patientinfo/translations

RCoA responds to 'Reducing Bureaucracy' consultation

The College has submitted its response to a consultation from the Department for Health and Social Care (DHSC) on the issue of 'Reducing bureaucracy in the health and social care system'. See the full response at: rcoa.ac.uk/rcoa-responds-reducing-bureaucracy-consultation

The College response highlights that the perioperative pathway could be a solution in improving the bureaucratic pressures associated with the above areas, as supported by comprehensive evidence in the CPOC impact review.



SALG-BIDMC Fellowship

The Safe Anaesthesia Liaison Group (SALG) is pleased to announce the next round of its exciting programme of fellowships for anaesthetists interested in patient safety. In collaboration with the Association of Anaesthetists and the College, SALG are offering a unique programme of formal training through Harvard Medical School that aims to develop international expertise in perioperative quality and safety.

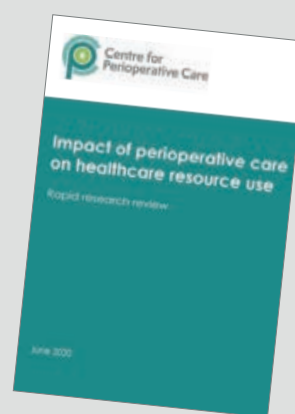
Further information and application details can be found at: bit.ly/SALGFellowship



Proving the case for perioperative care

The Centre for Perioperative Care (CPOC) has published comprehensive evidence that the perioperative pathway is associated with higher quality clinical outcomes, reduced financial cost and better satisfaction for surgical patients. Never has there been so important a moment to institute rapid large-scale transformation.

Read CPOC's report at: bit.ly/3imZYiy



NEWS IN BRIEF

News and information from around the College

Young anaesthesia artist 2020



While COVID has impacted us all as healthcare workers and, with some of us needing to spend more time away from our family than usual, it's also taken its toll on the little people we love and care so much for.

We'd like to offer your young daughters, sons, nieces, nephews or grandkids the opportunity celebrate with us as we take our first tentative steps to re-open your College, by asking them to send in their drawings or paintings of their interpretation of either what you did whilst caring for your patients, or of something they've enjoyed during the strange times they're living through at the moment.

We hope that seeing this new world through the eyes of our young family members will be a powerful and emotive insight into how this global pandemic has impacted on and is being perceived by the next generation.

We're planning to give this project pride of place in our building's entrance area, with each and every submission being put on display – we'd of course love to receive as many as possible!

Format:

- A4 portrait
- landscape is also welcome.

Postal submission instructions:

- drawing or painting on paper or card
- artists' first name and age, with parent or guardian's full name and email address clearly written on the back of the submission
- posted to: Young anaesthesia artist 2020, c/o RCoA Facilities Team, Churchill House, 35 Red Lion Square, London, WC1R 4SG.

Digital submission instructions:

- A4 portrait or landscape drawing or painting – scanned or photographed
- high resolution (300dpi) digital file to be emailed to: comms@rcoa.ac.uk with a subject heading of: Young anaesthesia artist 2020
- artists' first name and age, with parent or guardian's full name provided within the email.

Deadline for submissions is 20 December 2020.

We hope this provides our young artists with an enjoyable creative outlet and lots of fun. We can't wait to see the creations from our UK and international members alike.

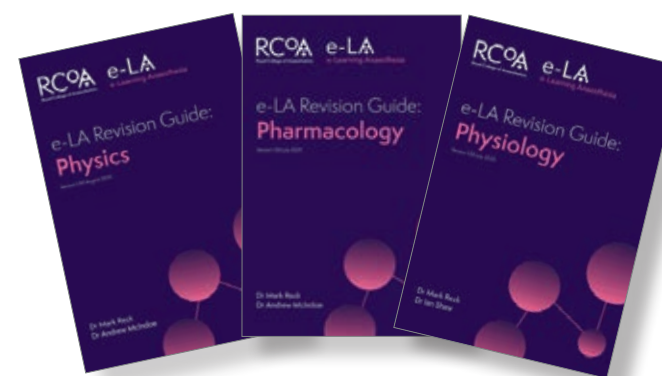
e-Learning Anaesthesia revision guides

We have now published all three new titles in the e-learning Anaesthesia revision guide series to complement e-LA and support Primary Exam preparation. The series now covers Physics as well as Pharmacology and Physiology. These guides are available to download for free onto your device for use offline and contain links directly to useful e-LA learning sessions.

Download the Revision Guides at: rcoa.ac.uk/e-learning-anaesthesia

e-LA is always looking for volunteer module editors and authors to make up the e-LA editorial board. Applications will be considered from all College members and anaesthetists in training who have achieved or are within a year of achieving their CCT.

To find out more please email: e-la@rcoa.ac.uk



Anaesthetic teams awarded for high quality patient care

This year the College is very proud to have recognised seven anaesthetic departments for providing the highest quality care to their patients. Departments at the five Trusts of the Countess of Chester, Frimley Health, Leeds, North Bristol and South Tees achieved accreditation and the two trusts of Kingston and St Georges achieved re-accreditation under the Colleges prestigious peer review scheme Anaesthesia Clinical Services Accreditation (ACSA).

As well as meeting the standards, the departments demonstrated many separate areas of excellent innovative practice. These included collaboration between hospitals in their trust, integrated services, flexibility of patient care and many more, these have now been highlighted for sharing through the ACSA network.

To receive accreditation, departments are expected to demonstrate high standards in areas such as patient experience, patient safety and clinical leadership. Whilst the pandemic has meant that onsite visits are postponed until March 2021, new anaesthetic departments can still register for the peer-review scheme and hold phone or video conferences to discuss the benefits of engaging and get advice on the challenges involved.

The College's website has all the information required for you to understand how ACSA could work for your anaesthetic department (rcoa.ac.uk/acsa).

Remember to get your flu jab!

The College would like to encourage you all to get your free annual flu jab as soon as you can. This is a critical step to keep you, your family and your patients safe. With COVID-19 in circulation it's especially important to get the flu vaccine this year to protect those most vulnerable and control pressures on NHS staff and services by reducing staff absence.

More information can be found at: bit.ly/2ZOdrst





Guest Editorial



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WHAT A DIFFERENCE A YEAR MAKES!

We have heard a lot about obesity in 2020 – that it predisposes to a worse outcome in COVID-19;¹ that the Royal College of General Practitioners has branded COVID-19 a ‘lifestyle disease’;² and that the Society for Obesity and Bariatric Anaesthesia are considering formulating guidelines regarding consent for obese patients, leading to the question of at what point this should happen preoperatively in an Association of Anaesthetists’ editorial.³

My declaration of interest on this is quite clear. Having been obese for most of my life, I had a revision from gastric band to gastric bypass in June 2019. I corrected someone on twitter a few months ago who called bariatric surgery a ‘quick fix’ – I’d say its anything but. More about recognising that there is a scary permanent option that involves not being morbidly obese. A year and a half on, it remains one of the hardest but best decisions I’ve made.

My first recollection of being overweight was in primary school, when I first got a nickname that stuck right through to the end of secondary school – ‘Fatty Forbes’. It is unfortunate being round and having a surname that starts with F when you’re seven years old. In medical school I was given a paper to present to my group by the professor of pharmacology in a fifth-year special study module. After looking me up and down, he had handed me a paper on Orlistat and told me that it was the ‘most appropriate’ paper he could find for me. Nowadays I’d have pulled him up on it, but at the time I certainly didn’t have the confidence or self-esteem to follow it through. You just want to keep your head down and get on with it; you’re mortified when anyone brings it up, but know it’s an issue as you do actually own a mirror.

Fast forward a few years to the place where I’ve probably heard the most judgement about obesity – the anaesthetic coffee room. Never aimed at me, but I’ve definitely noticed that, as a group, we are very judgemental. From a ‘harpooning whales’ on labour ward, to a having a ‘right heifer’ on the list, to an ‘OMG they’re h-u-u-u-ge’. It might be just coffee room ‘banter’, but we all need to be mindful of our perceptions and

bias towards these patients; they are most likely already terrified.

I originally had bariatric surgery back in 2007 when I got a gastric band. I worked with it fairly well for about a year, then I went off to Australia, fell out of follow-up, and did what all 25-year-old junior doctors do in Australia – PARTY!

It’s hard to recognise when something isn’t working; in reality I’d probably been thinking about revision to bypass for a few years before I decided to do it. There is usually a trigger that spurs you into action. For me, as a coffee addict, that trigger was experiencing shoulder pain, not only with eating but also on drinking my morning latte – DISASTER!

Undoubtedly the worst part was going to theatre as a punter, even when you’ve handpicked the anaesthetist and surgeon. The week before, my anaesthetics had involved liberal doses of both emergency drugs and buzzers. So my triple-figure tachycardia was perhaps unsurprising, despite the Remifentanil hitting like a full bottle of tequila.

Initially, the most challenging aspect of having a bypass for me was eating out. About three months post op, I was at a conference when I declined a beer from an old boss I hadn’t seen in 12 years. On declining the offer of beers I was firstly asked if I was pregnant. ‘No!’ Secondly, I was asked if I was an alcoholic. ‘No!’ And thirdly I was asked why on earth I didn’t want a dessert. It made me feel uncomfortable and very selective about going out socially for a few months.

I kept it very quiet till about six months post op, because I thought I’d be judged. Then came the Christmas party, when I decided I had two

options – tell folk, or don’t go out socially. I decided it would be much easier for ‘life’ just to tell ‘my people’. An excellent decision.

Its not all been a challenge though. I’m much less tired; I sleep better; I don’t have the anxiety that there won’t be scrubs that fit every morning, and don’t stockpile them in my locker anymore. The biggest anaesthetic achievement has clearly been coming third out of 73 on the Strava cycling segment on the way home from work; I need to gain 21 seconds to get second – I am considering the addition of a sail to the bike to achieve this.

As usual, I’ll add my Oscar-esque finale and thank all my Chichester crew for being awesome, in particular Ruth Prosser and Guy Slater. And I will finish with a reminder to us all: people will forget what you said, people will forget what you did, but people will never forget how you made them feel.⁴

References

- 1 Tamara A, Tahapary DL. Obesity as a predictor for a poor prognosis of COVID-19: a systematic review. *Diabetes Metab Syndr* 2020; **14**(4):655–659.
- 2 RCGP apologises after backlash over branding Covid-19 a ‘lifestyle’ disease (bit.ly/32ozO8l).
- 3 Selak T, Selak V. Communicating risks of obesity before anaesthesia from the patient’s perspective: informed consent or fat-shaming? *Association of Anaesthetists* 2020 (doi.org/10.1111/anae.15126).
- 4 Maya Angelou quote, goodreads (bit.ly/32IHRD3).



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SAS and Specialty Doctors

KEEP THE CHANGE...?

'The greatest danger in times of turbulence is not the turbulence, it is to act with yesterday's logic'

Peter Drucker

As we look back over the last few months (time of writing is August), we are reflecting on the many changes the COVID-19 pandemic has forced us to make within a short timeframe. There have been myriad changes to the way we work, and many of us are feeling exhausted and psychologically affected by the experience. Among the chaos and upheaval it has been astonishing to see how everything has suddenly come to a stop and we have reconfigured.

Locally, outside of London, we have had enough warning of the first wave to organise ourselves, crossskill, upskill, and practise multidisciplinary drills. The sense of common purpose was palpable in my hospital and has greatly improved interdisciplinary working and team spirit. The improvement in morale I have witnessed is reflected in some of our College COVID survey results.

Who knew how many consultations could be done electronically to mutual satisfaction? How multidisciplinary and anticipatory care plans, made on admission, would be the new normal, not a much-chased ideal? How we could change our working patterns or areas of practice at a moment's notice? How specialists who had barely ever crossed its threshold could become valued team members in intensive care? How we would run clinical governance meetings, business meetings, and educational events via videoconferencing, with better attendance than before?

We have learned new things about ourselves: we – and the NHS – can be very flexible if required. Changes contemplated for years can be implemented quickly if desired. We can regain our common sense of purpose. We can create efficient teams with flattened hierarchies and made up of previously considered unlikely team members. We can refresh old knowledge or learn new things, regardless of age. The public values the NHS and can adapt to new rules or ways in which healthcare is offered.

Focus on wellbeing and personal risk

Doctors from ethnic minorities are over-represented among SAS and trust-grade doctors, and their increased vulnerability to COVID has focused attention on personal risk and how to manage it. This does not only apply to ethnic background, but also to other

risk factors. In my personal experience of more than 26 years in the NHS this is a shift-change away from a 'one size fits all' approach. We are learning a different way of looking after staff, and some of that has been achieved with the help of the public: better food provision, availability of shower and rest facilities, soap and handcream, etc.

Most of us have in the past gone to work even if feeling unwell. The pressure to not leave your colleagues – already stretched – with your work on top of their own has led many a sniffly nose, a hacking cough, a fever, and an 'iffy' stomach to turn up at work. Those who are sick have felt guilty and often returned too early. We now have to provide a safer workforce and protect ourselves, our colleagues and our patients better. Personal protective equipment has taught us to take breaks. Presenteeism is dead!

Roll up your sleeves

The pause or slowdown in many services has now created a large backlog, and the consequences will only gradually come to light. We need to use some of the clinical innovations and gains made to create momentum as quickly as possible to get work done. Relaxation of bureaucracy and flexible thinking should help. We must resist attempts to return without question to business as before. Work desperately needs doing, but rest and recuperation are important. It is our duty to look after ourselves and our colleagues for us to be able to look after our patients.

Is this relevant to SAS doctors?

Attempts have been made to use changes in working patterns agreed as short-term measures during the crisis to embed longer-term changes, leading to an erosion of job plans and terms and conditions. There is a fine line between

SAS doctors are a much needed staff group

innovation and harnessing fresh thinking, and an opportunistic abuse of an exhausted, distracted workforce.

When meeting you at College events, many of you talk to us about dissatisfaction with job plans and terms and conditions. While such employment issues are not part of the College's remit, we try and signpost in the right direction – which is usually the BMA. However, we can also give you the confidence that we as SAS doctors are a much needed and difficult to recruit staff group with a significant vacancy rate. Many of you have worked in the same job and same location for years and are understandably reluctant and anxious to change. If you have recently changed the way you work and where you work, taken on different areas, taken part in different rotas, or been successfully redeployed, maybe this is the time to reconsider your options...

Opinions are my own and not the views of the RCoA.

Further reading

- 1 Third Covid Membership Survey, RCoA. (rcoa.ac.uk/news/third-rcoa-covid-19-membership-survey).
- 2 Workforce Data Pack 2018. RCoA (rcoa.ac.uk/media/5256).

Revalidation for anaesthetists

'Top tips' for making a successful CPD event application



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It was reported in the September edition of the *Bulletin* how the College's CPD accreditation process has now been extended to virtual learning events. An increasing number of these are being provided in response to ongoing concerns about local lockdowns and social distancing measures, potentially resulting in short-notice cancellations of face-to-face versions.

Consideration can be given to events which are appropriate to the professional development needs of non-trainees and for events which are targeted at a regional, national or international audience. There is no charge for NHS trusts and hospitals, registered charities and specialist societies and associations, and the event reviews are completed by independent, specialist CPD assessors, who are clinicians experienced in the subject matter.

We would like to use this article to provide some 'top tips' on how to make a successful application, and one which will be most visible and attractive to your potential audience:

- **event URL** – all events accredited for CPD appear in the Lifelong Learning platform (LLP) and on the College website, and so you are encouraged to provide a direct URL to increase visibility
- **keywords** – events are searchable by keywords in the LLP, and so adding some unique words will further increase visibility
- **aims and learning outcomes** – the overall aim(s) and learning outcomes of your event should be clearly defined so as to manage the expectations of the delegates as well as to provide guidance for the target audience. The learning outcomes should be measurable and should indicate what knowledge or skills the participants are expected to obtain as a result. These are particularly important because the attendees' reflection will be based on these.

- **CPD skills** – the incorporation of CPD into the LLP has seen a Framework of CPD Skills replace what was formerly the CPD Matrix. This is an entirely optional resource to map events against, although doing so, and also mapping against the *Good Medical Practice* domains and the *Domains for Medical Educators*, will further increase the visibility of your event in the LLP
- **supporting documents** – while the application process requires event providers to submit three mandatory documents – the event programme, information on the speakers and a copy of the feedback form, you can specify which of these, if any, you would like to be visible in the LLP.

We hope that this information will help; for further guidance please contact cpd@rcoa.ac.uk.



Faculty of Pain Medicine (FPM)

PAIN MEDICINE – MOVING FORWARD



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I am writing this FPM strategy update just before the schools return. This seems strange, as COVID-19 has overtaken much of this year's work, introducing both dilemmas and opportunities. Clinically there have been significant challenges, but redeployments are reversing, allowing the practice of pain medicine to return. Many centres have maintained some service for those most in need, which has been very encouraging.

Last September the FPM reviewed its strategy. This has allowed consistent messaging across the areas of training; professional standards; research; and public, professional and political interaction. There have been disruptions and delays, but we can list here highlights going forward.

- Pain management needs to be attractive and sustainable if patients are to benefit. Anaesthesia is a cornerstone for pain specialist development, and pain management is a fundamental component of the anaesthetic curriculum. There is also a role for broader access to pain medicine; this is being actively explored with the GMC credentialing process, which is now back up and running.
- These link with the strategic aim of looking at the Faculty's educational role with respect to healthcare as a whole. They comprise several independent strands that are being focused within a single hub to ensure consistency, improve access, and make the best use of resources.

The appropriate use of pain therapies is topical and important



(with the Medicines Advisory Group leading), and includes maintaining the 'Opioids Aware' resource.

- This all feeds the strategy to get the best service for our patients. This common objective is shared with the 'Core standards for pain management services' document, with outcome measures, with commissioning support, and with dialogue with NHS England and other statutory bodies. This has continued throughout the COVID pandemic, with new links being forged. The multidisciplinary nature of pain management is reflected in the good working

relationship with the British Pain Society. These interactions have allowed statements and publications to be co-released (both those that are COVID-related and those that are more general). Closer to home, there is ongoing engagement with the Centre for Perioperative Care.

The Faculty staff team provides the support that enables these activities to be undertaken and delivered in a timely manner. I salute them, as they have achieved this against the background of distance working, and the arrival of a new Associate Director of the Faculty together with other staff changes.



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Faculty of Intensive Care Medicine (FICM)

LIFE AFTER CRITICAL ILLNESS

The development of the critical illness aftercare service has been in the forefront of the Faculty of Intensive Care Medicine’s strategy and formed a part of the publication in 2017 of *Critical Futures. Life After Critical Illness (LACI)* was deemed to be an important workstream for the Faculty to undertake, working across multiple organisations.

The aims of the workstream are to:

- a present a UK-wide survey of current practice
- b provide an outline of existing service models
- c present examples of business cases
- d make recommendations about the future need for resources for these programs
- e outline future research proposals to evaluate existing services and outcomes.

The multiple organisations involved reflect the requirement for close collaboration across a spectrum of multidisciplinary organisations when exploring the optimal approach to planning and delivering.

Provisional guidance has been published to support the pandemic and provide a national framework for future critical illness recovery services. The Life After Critical Illness Working Party (LACIWP) of the Faculty will now continue its work on their full guidance document, and this will take into account any additional learning from the pandemic.

Until recently there was little in the literature about what happened to survivors of critical illness after they left hospital. In 1989, a King’s Fund report stressed that ‘there is more to life than measuring death’. Following on from this, there were several attempts in the UK to establish outpatient follow-up programmes, some of which were successful. However, due to a lack of funding and because of the perceived lack of an



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evidence base to justify their funding or their existence, many failed to be sustainable. Some centres did manage to evolve rehabilitation and outpatient follow-up services for patients after critical illness/injury. However, unlike specialties such as trauma, cardiology, respiratory medicine, and stroke medicine, where rehabilitation pathways are now quite well established, intensive care has been unable to develop a specific rehabilitation pathway.

In 2009, NICE provided guidance with the headline statement ‘Given the individual impact on patients, and ripple effects on families and society in general, poor-quality rehabilitation and impaired recovery from severe illness should be regarded as a major public health issue.’ [NICE CG83].

Unfortunately, this only achieved limited traction. In 2015, the Scottish Intensive Care Society Quality Improvement Group published guidance making critical care rehabilitation one of its

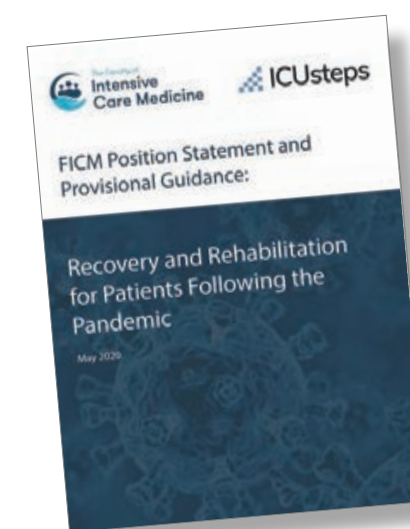
quality indicators. In 2017, NICE published its Quality Standard (NICE QS 158), and since then there has been more of a concerted effort for all intensive care services nationally to provide rehabilitation and follow-up. However, there still remains the problem of how to fund such services. To date, this has been primarily achieved by local intensive care units developing and submitting a business case to local commissioners. Unfortunately, these efforts often fail due to a lack of supportive clinical evidence and a challenging financial climate in the NHS.

It is clear that recovery from critical illness is complex. Since 2010, the term ‘post intensive care syndrome’ (PICS) has been increasingly used to describe the complex long-term sequelae of critical illness affecting both survivors and their families. PICS has three key patient-centred domains at its core that can be impacted upon by critical illness: the physical, the cognitive and the psychological domains, the latter affecting both patient and family. The question of who should provide intensive care aftercare services has stimulated debate about whether it should be intensivist-led or otherwise. The argument for these services being provided by intensive care staff is hard to contest, with numerous benefits for patients as well as for staff.

These benefits include feedback from patients and caregivers (family) to ICU staff that can influence changes in practice within the ICU, the enabling of revalidation for healthcare professionals, and the provision of a narrative of individual patients’ outcomes for staff, which can improve morale. The ICU multidisciplinary team are expertly placed to understand, interpret and plan the recovery phase of the patients’ illness and signpost them appropriately to other hospital or community-based specialties.

The patient feedback for these critical illness recovery clinics consistently highlights the benefit of hearing a narrative account of their ICU stay, along with the review and normalisation of their ICU delirium experience.

Some patients will have very severe ongoing disability following discharge, which requires specialist inpatient or community-based rehabilitation. Others require a variety of community-based rehabilitation/support services, including cardiopulmonary rehabilitation, sports and exercise medicine, psychological, vocational support, etc. All of these services need to be working in coordinated networks to optimise the care of patients who have been critically ill.



Download the FICM Position Statement and Provisional Guidance at: bit.ly/2Qob36Y

Patient perspective

SPOTLIGHT ON CRITICAL CARE



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Imagine that you're an awake patient or their relative in a critical care unit. You're in a frightening, alien environment. There are unfamiliar machines. Lots of them. They flash. They glow. They display restless neon numbers and tracings. It's often noisy. Very noisy. Equipment bleeps continuously. Raucous alarms sound insistently. Staff, dressed in identical scrubs, focus intently on their patients or huddle around charts and computer screens. They talk quietly in an unfamiliar language which seems to consist solely of letters and numbers. Mainly numbers.

Then there's a sudden, unexpected burst of activity as a new patient is admitted. After 20–30 minutes of toing and froing, everything settles down and anxious relatives are shown to the bedside.

Most people haven't experienced this and hadn't thought much about critical illness beyond hoping it didn't happen to them – until COVID-19 came along. Then the spotlight was switched on. People (and the media) started asking questions about critical care. They wanted to know what it was all about and what it would be like for them and their families if they became critically ill with COVID-19.

There were straightforward questions about everyday activities, like eating and drinking. There were also difficult questions, especially about decision-making. 'What if I don't want to be ventilated?' 'Who makes decisions about my care when I'm unconscious?' 'Will my family be involved in those decisions?' 'Who decides whether my ventilator is switched off?'

These are extremely challenging questions for critical care professionals and they have to be answered clearly and openly. As Dr Alison Pittard, Dean of the Faculty of Intensive Care Medicine (FICM), says:

'It is really important to not lose sight of who is the focus of our work. We may all have our own views and ideas but, at the end of the day, if this is not what the patient would want it is irrelevant.'

I'm the Lay Representative on the FICM Board, where I support FICM's work and particularly help critical care professionals communicate effectively with patients and the public. Dr Pittard succinctly sums up the value of the lay role:

'Having someone to represent the patient voice keeps us grounded and on the right track.'

When the spotlight turned onto critical care, Dr Richard Benson, Trainee

Representative on the FICM Board, had the idea of creating a multimedia hub for the FICM website. The aim was to answer some of those challenging questions people ask about critical care, presenting the information in different formats using everyday language.

I was very pleased to be asked to provide lay support for Richard's initiative. Dr Will English and Sarah Bean from the Royal Cornwall Hospitals NHS Trust also joined the group. They have considerable experience of successfully producing information for critical care patients and their families. Anna Ripley, Education and Standards Manager from FICM, also joined us. ICUSteps, a charity working with patients and families who have experienced critical care, gave invaluable lay feedback on draft materials.

The group decided to work around the theme of the patient's journey in critical care. That became the focus for a series of plain English FAQs for critical care patients and their families.

Will and Sarah's work in Cornwall resulted in a series of excellent videos offering accessible information in

a straightforward way. They very generously offered these to the project. The videos explore different themes associated with critical care. Importantly they cover rehabilitation and recovery, including the physical and psychological consequences of critical care. Each video includes frank narrative from real critical care patients which is deeply moving. Everyone involved in critical care should watch those videos; they're a clear window into the reality of life after critical care.

The hub is live on the FICM website at: ficm.ac.uk/intensive-care-guide-patients-families-friends. Richard's vision is that it will be expanded and continually developed to fulfil its potential as a key information source for patients, their families, and critical care professionals.

For most patients and their families, critical care units are strange, scary, alien places. Accessible information, produced through effective collaboration between professionals and lay representatives, can help people understand the critical care

environment. This helps ensure that what the patient wants is always the focus of decisions about their care.

The hub can be accessed at:
ficm.ac.uk/intensive-care-guide-patients-families-friends

SEAUK

Society for Education in Anaesthesia (UK)

Intergenerational differences and medical education



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A new generation is said to evolve every 20 years or so¹ with attributes, attitudes and motivations different from preceding and succeeding generations. They are based on defining historical events and societal trends, rather than strict genealogical generations as such.

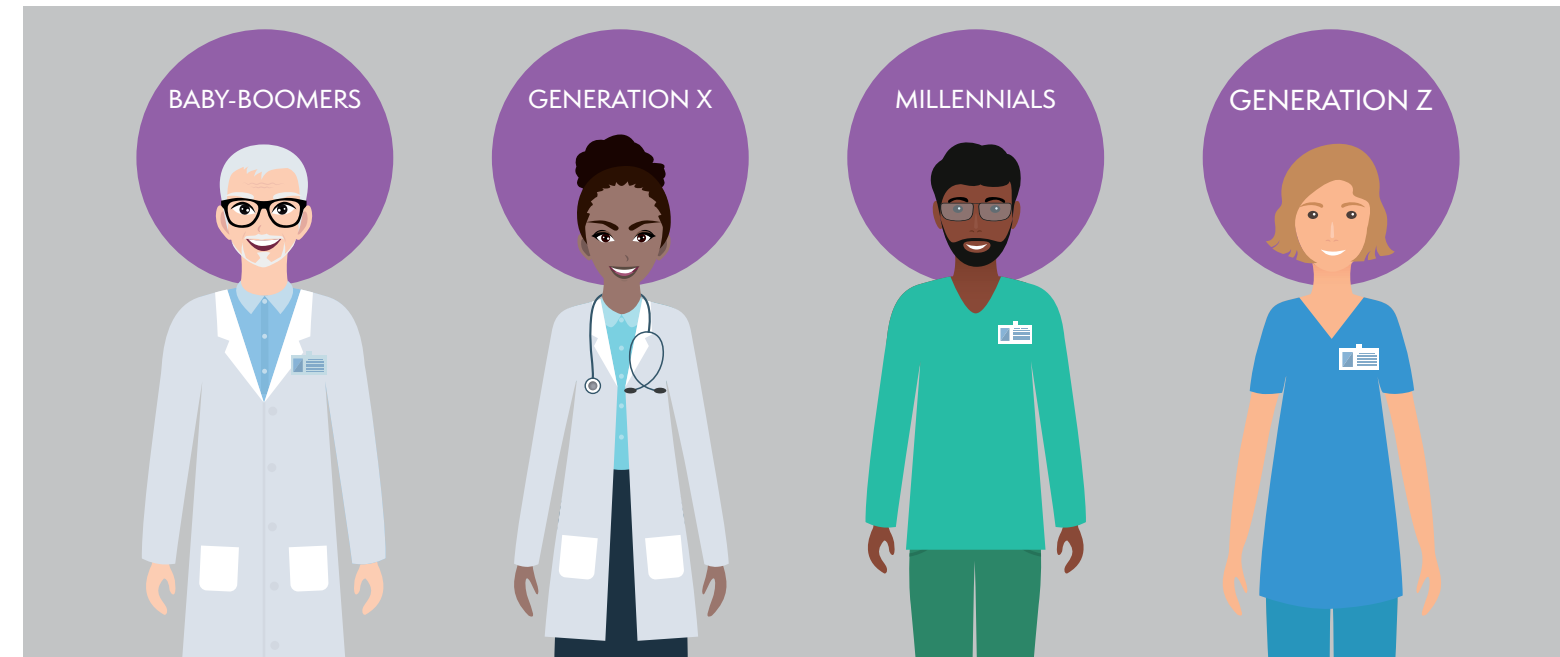
Our anaesthetic department in a large district general hospital comprises staff from across these generational boundaries. While the majority of consultants are 'Generation X' with birthdates between 1965 and 1985, a few of the older consultants lie in the tail end of the 'Baby-boomers' (born 1947–1964). Similarly the majority of anaesthetists in training are 'Millennials' (born 1981–1993 or so), but an increasing number of foundation and core trainees belong to 'Generation Z' (born after 1993). Our department is probably not atypical, and there is the potential for generational differences to lead to misunderstandings. Different generations also prefer to teach and learn in different ways – which increases the potential for misunderstandings, and techniques preferred by Millennial

learners may not be optimum for Generation Z, while both may be foreign to their Baby-boomer trainers.

Millennials entered adulthood at or around the year 2000. Their view of authority has been described as 'unimpressed', and they may need to be convinced of the value of rules rather than expected to accept them uncritically. This can lead to frustration in Baby-boomer trainers, who are more likely to be rule followers. Millennials are technologically sophisticated and used to immediate access to information, which they appreciate being presented in an engaging, interactive manner. However the legacy of 'helicopter parents' means that they may need guidance and focus in their learning with opportunities for support available.

They may therefore respond positively to teaching which has clear goals and timeframes and which aims to develop critical thinking skills rather than rote learning, yet includes a degree of freedom in how the learning outcomes are achieved.^{1,2} They have also grown up with social media and may need a more collaborative, team-based approach to learning than earlier generations.

The characteristics of Generation Zs as adults are only just being revealed. It is predicted that they will have a strong work ethic and be more risk-averse and traditional than Millennials. They are predicted to be achievement-focused rather than participation-focused and to want their careers to have a positive impact. This may be harnessed to affect positive change in the department



or organisation, and they may value the chance to make a difference. They have been entirely raised in the digital era with immediate access to information, and dislike uncertainty and waiting for situations or answers to emerge. However, their interaction with information and reality has changed with the emergence of digital 'echo chambers' which reinforce viewpoints and close down meaningful discussion with little critical analysis or engagement. In addition, they may have an active digital persona which may or may not reflect their true identity. This may lead to distress if the digital and real personae are in tension or if their real life is felt to be less perfect than the online life of their peers. This may be one factor in the increase in depressive symptoms and self-harm in Generation Z individuals, with increasing numbers seeking help from mental health services. For this reason, Generation Zs too may need access to support during training.^{1,3} They

also may need support in critical analysis of information available online.

Despite the differences, some common themes emerge. Both Millennials and Generation Zs may respond better to learning which is immersive and interactive and includes visual as well as audio input. They appreciate a degree of freedom in determining how their learning objectives are met. They appreciate feedback, particularly when this is given at, or shortly after, the event rather than at interim meetings.

These differences may be summed up in attitudes to email. A technique which did not exist when Baby-boomers entered training is seen by Millennials and Generation Zs as old-fashioned, taking too long, and obsolete!

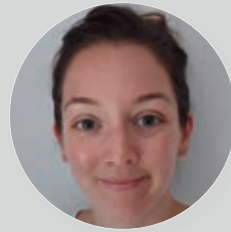
There is virtually no peer-reviewed research into this area in medical education, and the references given here are just opinion pieces.

Of course these descriptions are oversimplifications – perhaps to the point of being caricatures. It is important both to recognise that people are individuals and to treat each other as such. Part of this individuality, however, reflects the 'social, environmental and technological influences'² on doctors of different generations, and an understanding of these differences may help trainers to better support their trainees.

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- 1 Schenarts PJ. Now arriving: surgical trainees from Generation Z. *Journal of Surgical Education* 2019; 77:246-253. (doi.org/10.1016/j.jsurg.2019.09.004)
- 2 Roberts DH, Newman LR, Schwartzstein RM. Twelve tips for facilitating Millennial's learning. *Medical Teacher* 2012; 34:274-278.
- 3 Shatto B, Erwin K. Moving on from Millennials: preparing for Generation Z. *Journal of Continuing Education in Nursing* 2016; 47: 253-254.

There is the potential for generational differences to lead to misunderstandings



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CREATING CAPACITY IN A CRISIS

The COVID-19 pandemic has had a significant impact on the ways in which our hospitals and services run. The need to provide elective cancer surgery during this period has necessitated many changes to the way we work, and this has produced unanticipated benefits. In this article we discuss the way our pre-assessment clinic (PAC) at the Royal London Hospital (RLH) has adapted to reintroduce safe and timely elective surgery when faced with staff shortages and the risk of infection to patients and staff. While the pandemic has significantly impacted on service delivery in other clinical areas, in pre-assessment it has resulted in a more self-sufficient and efficient service.

Challenge 1: enabling decision-making in the absence of a continuous consultant presence

Prior to the pandemic, the PAC at RLH involved daily nurse and consultant-led clinics. Investigations such as iron infusions, echocardiograms and spirometry were arranged to take place in other outpatient departments. As a result, high-risk patients were likely to attend hospital a number of times and in various locations prior to their operation.

Within days, the PAC saw a greatly reduced consultant presence. While this was of less consequence in the initial phase, the re-introduction of elective surgery posed a number of challenges to our pre-COVID pathways. It became clear that there would be a greater dependence on the nurses to support and supplement the service by taking on new clinical, practical and

managerial skills. We approached these through protocol-driven pathways for investigations such as spirometry, increasing the level of autonomy and nurse-led decision-making.

With the lower initial throughput, the PAC nurses were able to utilise the skills they learned on the 'Principles of physical assessment' course run at RLH. After taking a full clinical and social history and conducting an examination, nurses now routinely perform screening for frailty and cognitive impairment using the Edmonton Frailty Scale and the Montreal Cognitive Assessment. This is followed by an objective assessment of fitness, such as the incremental shuttle walk test or a stairs assessment – particularly useful investigations in view of the suspension of cardiopulmonary exercise testing during the pandemic. Finally, appropriate protocols were written to enable nursing staff to request and perform additional investigations

such as brain natriuretic peptide (BNP), iron studies, echocardiograms, and spirometry.

This holistic approach has allowed us to identify patients at risk of requiring additional care in the postoperative period and to complete the necessary referrals to social services early, thus reducing length of stay. It has also facilitated consultant-led virtual reviews, and allowed us to diagnose silent disease and optimise patients with remote input from our colleagues in other specialties.

Challenge 2: minimising the risk of infection to patients and staff

One of the key considerations the COVID-19 pandemic has raised is the need to re-assess the ways in which patients are prepared for surgery. Minimising hospital attendances for multiple clinics and investigations is one



way in which we were able to reduce exposure and maintain self-isolation in the most vulnerable part of our population. This has also led to the biggest unanticipated benefit – the upskilling of our nursing staff to accommodate this.

Since the pandemic, the clinic is more self-sufficient. The members of our team with additional skills such as spirometry and venepuncture have trained others in the delivery of these services. We also introduced teaching and training so that the nurses are now able to deliver iron infusions. It requires careful logistical planning and management, but this upskilling means that these interventions can be carried out for a patient on the same day, and in the same area. This significantly reduces patient movement around the hospital, and has resulted in the evolution of a 'one-stop shop', with the surgical clinic, preoperative assessment, investigations, and optimisation done on the same day, thus minimising

hospital visits and risk of infection. Having our surgical colleagues in clinic on the same day has provided other benefits in facilitating dual conversations with our patients, and this comes very close to our ideal model of shared decision-making.

Going forward

We are mindful of the impact this model has on our patients and nursing staff, with the potential for information overload and fatigue in both groups. Our next goal is to reduce some of this burden by improving access to virtual information with video follow-up.

COVID-19 initially posed a huge threat to the smooth running of our pre-assessment clinics and to our goal of providing safe, urgent elective surgery for high-risk patients at RLH. However, our PAC nurses were empowered and motivated to learn new skills, collaborate, and share their knowledge and expertise. They came together as a team to

ensure thorough pre-assessment, investigation, and optimisation of high-risk patients for complex major surgery. Through this, they created a highly efficient 'one-stop shop' pre-assessment model which has ensured thorough and holistic patient assessment and facilitated shared decision-making during a time of crisis. It is a highly deliverable and replicable service, and COVID-19 was the main driving factor. We have come back to an unexpectedly more streamlined and self-sufficient service, and this model allows us to have more time for meaningful consultations with our patients around their risk, expectations, concerns, and patient journey.

The authors would like to thank our nurses, the matron for pre-assessment, the anaesthetic department, and the management team for their enthusiasm, drive, and support during this time.



Remote pre-assessment for cancer surgery during the COVID-19 pandemic

The COVID-19 pandemic has been the biggest health threat the NHS has faced. The enforcement of lockdown came with uncertainty for cancer care, though cancer services did continue, coordinated by specialist cancer hubs, based on the NHSE surgical prioritisation system for elective cancer surgeries. The Royal Marsden hospital (RMH) was one of the hubs providing essential cancer surgery to patients from 10 trusts across London, seeing 600 patients through surgery and pre-assessment during its first three months.



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We are anaesthetic registrars, who, due to shielding restrictions, worked remotely for the RMH admissions and pre-assessment unit in the newly set up hub, new roles which posed an array of clinical challenges. We assessed patients with nursing staff on site and an overseeing consultant to whom cases could be escalated.

The hub was set up rapidly to address the needs of cancer patients during the early phase of the coronavirus pandemic. Initially, seeing patients while new pathways were being established meant pulling together as a team, with doctors seeing patients before nursing staff, and without administrative support. After the first month, the clinic ran in a similar framework to the pre-lockdown model, albeit with a proportion of the doctors working remotely. Significant challenges included the fact that the time frame between referral and surgery was often less than a week, and that patients were often referred to the clinic with little background information, challenging us to optimise care in a timely manner to facilitate oncological surgery.

Patient assessment is standard practice for any anaesthetist, but key elements were different when consulting remotely. Asking patients for an estimation of their weight, airway issues and functional capacity is asking them for information usually attained objectively and gathered over a face-to-face consultation. However, instead of assessing functional capacity with cardiopulmonary exercise testing or six-minute-walk tests, our experience

using the Dukes Activity Status Index was positive, and we felt the resulting scores matched the subjective impression of a patient's status during telephone assessment. Patients were risk-stratified and their consent gained for anaesthetic risks as well as for perioperative COVID infection risk.

To keep COVID transmission rates low within the hospital, all patients were advised at the time of referral by their base hospital to self-isolate for 14 days pre-operatively. Then, following remote pre-assessment, patients came in person to a single preoperative clinic visit 48 hours prior to surgery for COVID swabs and also routine observations and investigations. Aware of this small window of time to act on results, we had to pre-empt any potentially abnormal results and often chase historical results from GP and hospital records to help gauge whether to bring patients in earlier for investigations, knowing that an additional hospital visit means increased exposure risk.

Though the day was often busy, we felt that we were able to give more time to patients and, in their home environment, they seemed more forthcoming with their histories and were appreciative of the time spent with them. Working from home was different, and we had to learn to switch off, which is difficult to do in an environment where you don't actually leave work – it is easier to walk away when your work space isn't also your dining table. Juggling childcare, home schooling, and working from home were also new, with children not understanding that parents being at

home doesn't mean being available to them, and that parents being key workers when they are shielding doesn't allow for them to go to school.

The biggest change to our job responsibilities was the removal of practical skills and having to redefine our role as 'working from home' anaesthetists. Our practical nature and our involvement in rapidly changing clinical situations defines our role in the hospital setting, and without that we had to adapt. We were grateful to be part of something very relevant during this time, though it seemed far removed from what we would have thought we would be doing in a pandemic.

We have collected cancellation data and compared it to the same time period last year to assess if we provided an equivalent service despite changes due to the pandemic. We found that, once cancellations due to positive COVID screens were excluded, the overall cancellation rate was comparable.

Overall, the remote pre-assessment was a success. It allowed staff members who were shielding to work in a relevant and fulfilling role while also assessing patients in the safety of their own home. Feedback received from visiting surgeons has been very positive, and this was rewarding to receive. The Cancer Hub will continue to provide for patients across London as long as there is a need for its service. Ultimately, we hope we have created a framework that can be used in other institutions to help with remote assessment of patients requiring surgery in the COVID era.



PERIOPERATIVE JOURNAL WATCH

Dr Charlotte Crossland, ST4, Kent, Surrey & Sussex Deanery and Dr Jia Liu Stevens, ST6, Central London School of Anaesthesia

Association between intraoperative intravenous lidocaine infusion and survival in patients undergoing pancreatectomy for pancreatic cancer: a retrospective study

This study evaluated the outcomes of 2,239 patients after pancreatic surgery, which included non-lidocaine and lidocaine groups. Propensity score matching was performed to minimise bias. Lower opioid analgesia was used both intra- and postoperatively in the lidocaine group. The length of stay was similar between groups. The overall survival rates at one and three years were higher in the lidocaine group than in the non-lidocaine group (68.0% vs 62.6%, $P < 0.001$; 34.1% vs 27.2%, $P < 0.011$). The multivariable analysis indicated that intraoperative lidocaine infusion was associated with a prolonged overall survival (HR=0.616; 95% CI, 0.290–0.783; $P < 0.013$). However, there was no difference in disease-free survival between groups (HR=0.913; 95% CI, 0.821–1.612; $P = 0.316$).

Zhang H *et al.* *BJA* 2020; **125**(2):141-148

Personalised haemodynamic management targeting baseline cardiac index in high-risk patients undergoing major abdominal surgery: a randomised single-centre clinical trial

This trial randomised 188 high-risk patients undergoing major abdominal surgery to routine care or personalised haemodynamic management. In the latter, a personal cardiac index was targeted using algorithm guided IV fluids and dobutamine. The primary outcome was a composite of major complications or 30-day mortality. 30% of patients in the intervention group experienced complications compared with 55% of controls (relative risk: 0.54, [CI]: 0.38 to 0.77). 30-day mortality was 1/94 patients in the personalised therapy arm compared to 5/94 patients receiving routine care ($P = 0.097$). There were no clinically relevant differences for secondary outcomes, including length of stay, 90-day mortality and postoperative morbidity. The authors conclude that a personalised approach to haemodynamic management reduces major postoperative complications or 30-day mortality.

Nicklas JY *et al.* *BJA* 2020; **125**(2):122-132

Perioperative use of gabapentinoids for the management of postoperative acute pain: a systematic review and meta-analysis.

The aim of this systematic review was to assess the analgesic effect and adverse events of perioperative gabapentinoids in adult patients. 281 randomised controlled trials were included; the primary outcome was intensity of postoperative pain, with secondary outcomes including chronic postoperative pain, cumulative and persistent opioid use, and adverse events. Although gabapentinoids were associated with lower postoperative pain intensity on a 100-point pain scale (at 6 h, 12h, 24h and 48h) (mean differences, -10, -9, -7, and -3 points respectively). However, these effects were not clinically significant (set at >10 points out of 100). No effect was observed on pain intensity at 72h, or on subacute and chronic pain. Postoperative nausea and vomiting was slightly lower with use, but adverse events of dizziness and visual disturbance were greater. This meta-analysis calls into question the routine use of gabapentinoids in the perioperative period, as their benefit appears very limited.

Verret M *et al.* *Anesthesiology* 2020; **133**(2):265-279

Accuracy and feasibility of clinically applied frailty instruments before surgery: a systematic review and meta-analysis.

The association of frailty with poorer perioperative outcomes is well established. This systematic review looked at the association between individual frailty scales and clinical outcome, and also assessed feasibility of individual tools. 70 studies were included with 35 different frailty tools. The primary outcome was mortality. Most strongly associated with accuracy in predicting mortality and discharge-not-to-home was the Clinical Frailty Scale (odds ratio, 4.89; 95% CI, 1.83 to 13.05 and odds ratio, 6.31; 95% CI, 4.00 to 9.94, respectively). The Edmonton Frailty Scale predicted complications best, and the Frailty Phenotype was most strongly associated with delirium. The Clinical Frailty Scale had the highest reported measures of feasibility. The Fried phenotype scored highly in general accuracy but lower in feasibility. The authors conclude that the Clinical Frailty Scale had the best combined results in accuracy and feasibility.

Aucoin SD *et al.* *Anesthesiology* 2020; **133**(1):78-95.

The College is committed to developing a collaborative programme for the delivery of perioperative care across the UK: cpoc.org.uk

HEALTH SERVICES RESEARCH CENTRE Annual Report 2020



Professor Ramani Moonesinghe
Director, Health Services
Research Centre



Professor Iain Moppett
Deputy Director, Health Services
Research Centre

As with every aspect of College work, HSRC has been affected by the COVID pandemic. Perhaps the most important part of this HSRC update is to say a big thank you to all those working with HSRC who have adapted to new, uncertain and constantly changing ways of working over recent months.

Our fellows and clinical leads supported clinical work in their local areas and still found time and energy to make progress with HSRC projects. The HSRC team at the College continued their admirable support – albeit from their virtual offices, gently reminding us all when we are (yet again) talking at length on mute.

During the peak COVID-19 period, various HSRC projects went on hold, while some such as NELA carried on in a reduced form. We don't know what the perioperative landscape is going to look like in the future, but most projects are now back on stream, collecting data as before, or planning for starts next year.

One of the things we are proud of within HSRC is providing opportunities and development for trainees. It has been a real pleasure for us to see

current and recent fellows putting their talents to good use in projects related to COVID-19 and outside the HSRC remit. Danny Wong has been a driving force behind the IntubateCOVID registry; Emira Kursomovic's work on COVID-related deaths in healthcare workers was picked up by national media; and the NAP7 fellows, Richard Armstrong and Andrew Kane, somehow managed to produce a systematic review of ICU outcomes following COVID-19 in a matter of weeks.

Talking of congratulations, Danny Wong successfully defended his PhD thesis – based on his work on SNAP-2. Another PhD in the HSRC library – many congratulations, Danny.

The work of the HSRC relies on numerous external funders who provide support for individual projects, including

the Healthcare Quality Improvement Partnership, the Health Foundation, the Association of Anaesthetists, the Association of Paediatric Anaesthetists, the National Institute for Health Research, and the University College London Surgical Outcomes Research Centre. But that support would achieve nothing without the engagement and encouragement of members of the College and our many colleagues from other professions. Thank you.

We hope you find this year's update on HSRC activities interesting. We can't fit everything in to one issue of the *Bulletin*, so we'll keep you posted on our projects in future issues. If you want to find out more, just get in touch.

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Sprint National Anaesthesia Project 3 (SNAP-3)

FRAILTY AND DELIRIUM



Professor Iain Moppett, Lead Investigator, SNAP-3

Coronavirus may have delayed things a little, but preparations for SNAP-3 are well underway. So what is SNAP-3 all about, who's involved, and when is it going to happen?

Frailty and delirium

The headline aim of SNAP-3 is to describe the impact of frailty and delirium, and their management, on outcomes following surgery. This will involve data collection from around 12,000 older people undergoing surgery over one or two weeks. Like all good projects we've got some outline objectives to achieve this aim:

- identify the role of frailty in predicting perioperative outcomes across all surgery types (day surgery, elective, urgent/emergency)
- identify associations between hospital-level and patient-level frailty-related interventions and outcomes
- describe the variation in hospital-level and patient-level frailty-related interventions
- develop and internally validate a risk-prediction tool for postoperative delirium.

Who's involved?

This is very much a collaborative effort. We're delighted to have Dr Judith Partridge co-leading the project. Jude is a consultant geriatrician based at Guy's and St Thomas' Hospital, London, who has been heavily involved in developing

the Perioperative medicine for Older People undergoing Surgery (POPS) service and is an expert on frailty. The team also includes Dr Akshay Shah (Specialty Registrar in Anaesthesia and Intensive Care Medicine, Oxford Deanery); and Dr Jugdeep Dhesi (Vice-President of the Centre for Perioperative Care, geriatrician, and lead for POPS). Dr Tom Poulton is helping us from the other side of the world, with plans to collaborate with centres in Australia and New Zealand too.

The success of SNAP-3 will depend on the engagement and enthusiasm of the anaesthetic community, particularly our amazing trainees. We'll be looking for senior trainees who want to coordinate their local sites and for folk to help with data collection. Getting your name on a publication isn't everything, but it is one way we will be acknowledging all those who are actively involved. We are exploring potential links with our



Dr Judith Partridge will be co-leading the SNAP-3 project

Timescales

There is considerable uncertainty about what surgical services will look like in the medium term, but we are hoping that we might be collecting data in 2022. Hopefully, we will have settled into some sort of new routine by then.

I hope that College members will find the project interesting and relevant to them and their patients. We'll keep you updated on progress.

colleagues in geriatric medicine to see how SNAP-3 might create opportunities for collaboration.

Trainee lead investigator

There is a key role for a trainee lead investigator – hopefully they will have been appointed by the time you read this.

The SNAP team can be contacted via email at hsrc@rcoa.ac.uk



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Dr Andrew Kane
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Dr Emira Kursumovic
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Dr Richard Armstrong
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Professor Tim Cook
Director of the National Audit Projects, RCoA

National Audit Project 7 (NAP7)

PERIOPERATIVE CARDIAC ARREST



In early March, the NAP7 team decided to delay the project's planned May 2020 launch. Despite the postponement, work has continued with regular meetings with both the stakeholder panel and the HSRC leadership team.

A key decision was to survey all the NAP7 local co-ordinators about their views on relaunching NAP7. The local co-ordinators have a vital role in the running and success of the National Audit Projects (NAPs), and their opinions have helped inform decisions about the project. Most of the co-ordinators responded (72%) and gave huge support to continuing with the

current NAP topic. Many co-ordinators felt that departments would not be ready to start NAP7 until the new year, with next spring the most popular choice (ie, about a year later than planned). The main reasons were concern about a second wave of infections and allowing time for a return to a more normal situation. The co-ordinators also told us that they were keen that

we addressed COVID-19 related issues, such as the COVID-19 status of patients, whether they have been vaccinated, the use of PPE, and the impact of COVID-19 on perioperative cardiac-arrest care. Another message was that data collection for the three parts of NAP7 (baseline survey, activity survey, individual case reviews) had to move away from the paper processes used in previous NAPs. In response to this survey and to feedback from the stakeholders' panel, the tentative plan is to launch NAP7 in about May 2021 and we are exploring simpler ways to collect data.

One challenge (and potential opportunity) for NAP7 is the impact COVID-19 has had on anaesthetic activity and how this will impact on our ability to determine an estimate of total anaesthetic activity. To determine the denominator and build a picture of national anaesthetic activity, we will capture data on every case under the care of an anaesthetist in every department over four days. It

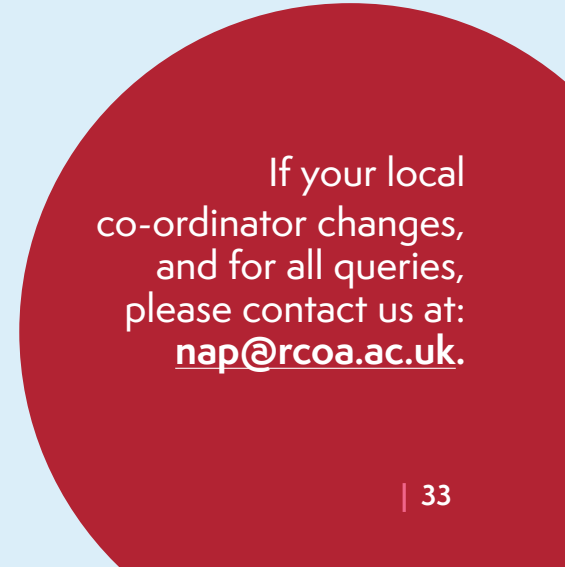
is also important for us to understand and track the return to normality within departments, and the NAP team will be undertaking further surveys of local coordinators in the coming months to assess changes in activity levels and departmental organisation.

Finally, the key to NAP7, as with previous NAPs, is you! We will depend on all UK anaesthetists to work together to take part in the baseline surveys and activity surveys, report eligible cases, and support their local co-ordinators.

Further details

Full details, FAQs and the name of your local co-ordinator can be found at nationalauditprojects.org.uk/NAP7-Home

You can now also follow us on Twitter [@NAPs_RCoA](https://twitter.com/NAPs_RCoA)



If your local co-ordinator changes, and for all queries, please contact us at: nap@rcoa.ac.uk



National Emergency Laparotomy Audit (NELA)

FELLOWS PAST AND PRESENT

Research fellows have been part of the National Emergency Laparotomy Audit (NELA) project team since 2012. In the early years they contributed to establishing the audit, and they have gone on to use the data collected to explore ways to improve care for some of our highest-risk patients.

NELA research fellows represent the multidisciplinary nature of the audit, and include anaesthetists, surgeons, and care-of-the-elderly physicians. With the support and supervision of the project team, fellows are not only involved in the organisation and running of NELA but can also undertake their own research, with the option of working towards the attainment of a higher degree.

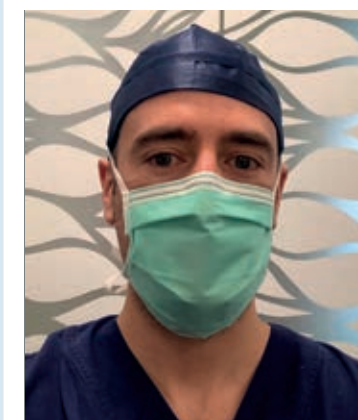


Dr LJ Spurling

HSRC NELA Fellow 2017 to present

The first NELA meeting I attended was the annual 'awayday' where the strategy for the next year of the NELA project was planned. This gave an immediate (and mildly overwhelming) feel for the sheer scale of the project and for how many elements need to be balanced to keep the project going. The NELA Project Team has experts in so many fields: quality improvement, data analysis, research, project management – to name but a few. With the breadth of work and this concentration of knowledge and experience, any fellow will be able to find their niche.

Thanks to the support of two outstanding academic supervisors, the project team and, of course, all those who participate in the NELA project, I am currently writing up my PhD thesis. The work done so far with the incredible volume of data has only scratched the surface. Opportunities abound for a future fellow to take on research and quality improvement projects, big or small. I am incredibly grateful to everyone I've had the pleasure of working with while on this journey.



Dr Tom Poulton

HSRC NELA Fellow 2016 to present

As one of the earlier NELA HSRC fellows, I began my OOPE in February 2016. With no research background, and no real plans for research to be a major part of any future job, it started out as being just for a year. While it came with a number of challenges, the role was such an enjoyable and positive experience overall that one year quickly became two. I returned to part-time training after the first 12 months and have since CCT'd, but I have remained affiliated with the HSRC because I found myself taking on an MD(Res), which was later converted to a PhD. Now, more than four years later, I am (hopefully) a few months from submitting my thesis. I say hopefully, not because I'm tired of the work, far from it, but simply because I have developed a habit of saying yes to opportunities that have subsequently presented themselves, and the next project awaits. I don't have a single regret for taking the time to do the original fellowship and am hugely grateful to the wonderful people I've been able to learn from along the way.



Miss Hannah Javanmard

Current NELA Surgical Research Fellow (PhD in progress)

I had been involved in research from early on in my career, through my undergraduate degree and later an academic foundation training programme. Higher surgical training is so busy, and I didn't find that I had sufficient time to get involved in large-scale research outside of working hours. The previous NELA Surgical Research Fellow had such great things to say about their experience that when the opportunity came up, I jumped at it! So far it has been a really interesting behind-the-scenes look at what it takes to run a huge national project.



Dr Emma Stevens

HSRC NELA Fellow 2019 to present

After completing core anaesthetic training, I undertook an Improving Global Health fellowship focusing on an interest in quality improvement and system-strengthening work. I was initially concerned that, as a junior trainee with no clinical research experience, applying was a bit of a long shot, but I was delighted to be offered the post and can only recommend that you don't let these things discourage you from applying!

The year has passed incredibly quickly, and despite COVID-19 obviously having had a significant impact for a large part of that, I have still had a fantastic time. I got a real insight into the complexities of running a national audit and the breadth of skills and backgrounds needed within the team, and I'm incredibly grateful to everyone

I've met for sharing their experience and enthusiasm. Although I am looking forward to going back into training, I'll definitely be looking out for the opportunity to undertake a similar role in the future

The NELA team can be contacted via email at info@nela.org.uk



Perioperative Quality Improvement Programme (PQIP)

A YEAR OF TWO HALVES

Dr Samantha Warnakulasuriya, Post-CCT HSRC Fellow

It has been a year of two halves for PQIP. In September 2019 we released our second annual report¹ highlighting our top priorities for improvement, and we were excited to welcome our local contributors from around the country to our collaborative event at Kings Place.

At this event, leading experts in perioperative care discussed the improvements in care revealed by PQIP data, how to make the most use of local data, and opportunities for future change.

With 124 sites recruiting around 1,000 patients each month before COVID-19, the PQIP dataset includes risk, process and outcome data on more than 30,000 patients undergoing major elective non-cardiac surgery.

As the previous year's data had shown, while improvements such as in drinking, eating and mobilising have been encouraging, there remained some areas where it had been difficult to bring about change, for example risk assessment, HbA1c measurement, and perioperative pain management. We have aimed to improve collaboration through greater sharing of information between surgeons, nurses and allied health professionals, and encouragement of regular, multimodal communication and the building of discussion of PQIP data into routine clinical meetings.

During the COVID-19 pandemic

As has happened with most research studies, during the period when NHS resources have been stretched as a result of the pandemic, our collaborators have had to focus on the pressing need of managing the surge.

However, elective surgery has continued during the COVID-19 pandemic, due to the time-critical nature of major cancer surgery. Thirty-four of our collaborative sites have continued to recruit during these difficult times, and we are very grateful to all our collaborators, who have gone above and beyond to ensure that we capture data reflective of these unprecedented times.

Post-COVID-19 recovery

The PQIP national team is aware of how local research teams have been stretched, and will be offering support to sites that will be moving to restart recruitment. Patient and staff safety is a priority, and therefore we have applied for approval to approach and consent patients by telephone or video call,

allowing local teams choice in deciding how to structure their recruitment processes in a socially distant manner. In addition to restarting at our existing sites, we're excited that new sites will be participating in PQIP going forwards, and we look forward to welcoming our first site in Northern Ireland.

The baseline database of nearly 30,000 patients recruited before COVID-19 which changed all of our lives offers a unique opportunity to compare processes and outcomes of care before, during and (hopefully) after the COVID-19 pandemic overall, and to evaluate the changes in NHS structures and processes of care resulting from COVID-19 surges.

The future

As sites recover from COVID-19 related constraints and recruitment picks up pace, we will continue to support teams in delivering their quality improvement (QI) goals, both through resources on our website and targeted support of local teams by the national PQIP team. Restructuring of hospital pathways offers an opportunity to integrate



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changes, for example in pre-assessment services, and thus to overcome inertia in previously entrenched processes.

An example of how we will be supporting sites in their quality improvement work can be seen in the QI initiative designed to optimise perioperative anaemia, one of this year's Commissioning for Quality and Innovation (CQUIN) targets.² Additions to the PQIP dataset and the tools on our website will allow local teams to track their performance and plan improvement as required to meet the CQUIN target.

We are also delighted that a collaboration between PQIP and the Perioperative Clinical Trials Network, led by Dr Joyce Yeung from Birmingham and Warwick, was awarded NIHR

funding to deliver a randomised controlled trial of total intravenous anaesthesia vs. inhalational anaesthesia in patients undergoing major surgery, for which recruitment will begin in 2021.

If you're not already involved in PQIP, please do visit our website at: pqip.org.uk and explore what our project and dataset has to offer.

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- 1 PQIP Project Team. Perioperative Quality Improvement Programme Annual Report 2018-19. RCoA, London 2019.
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The PQIP team can be contacted via email at pqip@rcoa.ac.uk



The Children’s Acute Surgical Abdomen Programme (CASAP) IN A CHANGING LANDSCAPE



Dr Amaki Sogbodjor, CASAP Research Fellow

CASAP is the Health Services Research Centre’s first paediatric perioperative medicine endeavour. Supported by the Association of Paediatric Anaesthetists and the British Association of Paediatric Surgeons, this cohort study is evaluating the care and outcomes of children undergoing emergency abdominal surgery across the UK.

CASAP’s first participant was recruited in November 2019, and study sites were joining by the dozen when the COVID-19 pandemic arrived in full force. During this time, the priorities of the research world also shifted towards supporting efforts to combat COVID-19. As a result, data collection for CASAP stopped in many sites between March and June, but it is picking up again and for that we are truly grateful to our many collaborators.

Importantly, it has become apparent that the research aims of CASAP remain critically relevant as we find ourselves living alongside the virus and children continue to present with acute abdomens. In response to the pandemic, children’s services underwent considerable reconfiguration across the UK, with the increased centralisation of services in some regions. Although

the new set-up is somewhat fluid and is likely to be subject to further changes, it is crucial – arguably now more than ever – to understand the degree to which variations in the provision of perioperative care to children exist. As a result, we have updated the study protocol to account for this new landscape. Changes include questions to understand COVID-19 status in children having surgery, and the opportunity to gain consent using virtual means rather than face to face. We are also now able to gain consent retrospectively from parents of children who had surgery during the pandemic peak in the spring, so that we can capture important information about the care and outcomes of children treated when NHS services were under such unusual pressure. All of these amendments will enable us to gain a

unique insight by comparing processes of care and outcomes for children having emergency abdominal surgery before COVID-19 existed, during the height of the pandemic, and then beyond into 2021.

Children and young people aged between 1 and 16 years on the date of surgery are eligible for inclusion. Prospective data on risk, processes and inpatient complications will be linked to NHS Digital databases to determine longer-term outcomes over 10 years. At the time of writing we have 77 sites participating, with almost 600 individual participants having been recruited and additional sites waiting to join our team. We are open to more centres joining our efforts, so if you’d like more information email us at CASAP@rcoa.ac.uk.

A fellow in the field of rapid qualitative research

Dr Georgina Singleton, HSRC Fellow

After completing my ST5 year, I commenced my fellowship with the HSRC in February 2020 working with the PQIP team. However, owing to the COVID-19 pandemic, much of my planned work was disrupted.

Given my growing interest in qualitative research. I was presented with the opportunity to work with Dr Cecilia Vindrola and the RREAL team. To date, I have contributed to several streams of work, the first of these being the research study which aims to explore healthcare workers’ perceptions and experiences of COVID-19 in the UK. My role has involved enrolling participants into the study and conducting telephone interviews with a wide range of healthcare workers across several trusts. A large part of my work has involved the analysis of data – from identifying the early themes to the in-depth analysis of key topics.

RREAL has undertaken a significant volume of work exploring the impact of COVID-19 on cancer care. One of these projects was a global mixed-methods survey of the implications of COVID-19 for the delivery of systemic anticancer treatments. This work involved a multidisciplinary team of both researchers and clinicians. Given my clinical background, I assisted in the design of the questionnaire from conception to ‘roll-out’, ensuring that the questions were both relevant and clear to our multidisciplinary target audience. It is hoped that findings from this survey will enable a better

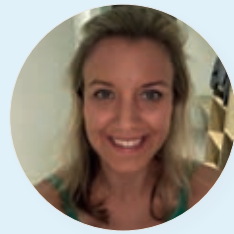
understanding of the current global measures employed to preserve cancer care during the pandemic and will inform the response in the event of a future wave.

I am currently involved in another project relating to cancer care during the pandemic. This ongoing study, using semi-structured interviews, aims to explore both patient and staff experiences of cancer surgery delivered using a regional-hub approach. Individual reflections should provide important learning, which may result in future changes in both processes and behaviours during a pandemic.

Through my affiliation with the RREAL team I was invited to join several national and international meetings during which clinicians’ experiences of managing patients with COVID-19 were discussed. My role involved the recording, extraction and synthesis of data to facilitate the production of a report which could be widely disseminated among critical care teams. My knowledge of anaesthesia and critical care enabled me to review the data from a clinical perspective, and this complemented the work performed by the research team.

During the last few months, I have had the opportunity to attend workshops on interviewing and qualitative analysis and have felt very supported by the research group. I have enjoyed numerous aspects of the work, from interviewing to report writing, during what has been a challenging time for many. It has been a privilege throughout my interviewing to listen to people’s genuine thoughts and feelings, knowing that these reflections should influence future practice.

Although the year has been totally different from the one that was planned, commencing my fellowship at the time of a pandemic has been a very interesting, challenging and enjoyable experience. During my fellowship so far I have gained some invaluable insights into the field of qualitative research. The value of qualitative research comes from how the data are collected, processed, interpreted and framed, and how these are contextualised and communicated. In addition, I have seen the importance of delivering findings in a timely way in order to inform the pandemic response effort. I look forward to my continued work within this field and to gaining further knowledge and experience of qualitative research methodology.



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TRANSFORMING PAEDIATRIC MAJOR TRAUMA CARE

Paediatric trauma is the leading cause of mortality and disability in children worldwide.¹ However, over the past decade since the creation of regional trauma networks in England, management of major paediatric trauma has transformed. Trends in injury pattern have also changed, with a notable rise in the incidence of penetrating trauma in adolescents.²

Four networks form the London Major Trauma System (LMTS). The Royal London Hospital (RLH) forms the 'hub' of the North East London and Essex Trauma Network. RLH provides all paediatric specialist care except elective neurosurgery and cardiac surgery.

Following NHS England peer review in 2017, it was recommended that time should be allocated to lead clinicians for the ongoing development and management of the paediatric trauma service. Moving forwards, specialty leads from paediatric anaesthesia, intensive care and surgery combined to develop the RLH service in a multidisciplinary fashion. This extended to create the Pan-London Paediatric Trauma Group with nominated leads from each network.

Objectives

To map the existing paediatric trauma service at RLH with the identification of key areas for development. This was divided into three main areas:

Clinical

- set up a joint working policy with co-located adult trauma teams
- develop the paediatric neurotrauma service to enable time-critical emergency neurosurgery on site
- establish a transitional service for adolescent trauma
- create patient-centred paediatric trauma pathways

Education

- establish courses to promote multidisciplinary team working

Research and quality improvement

- standardise trauma care across the London system
- assess current delivery of paediatric trauma care across London.

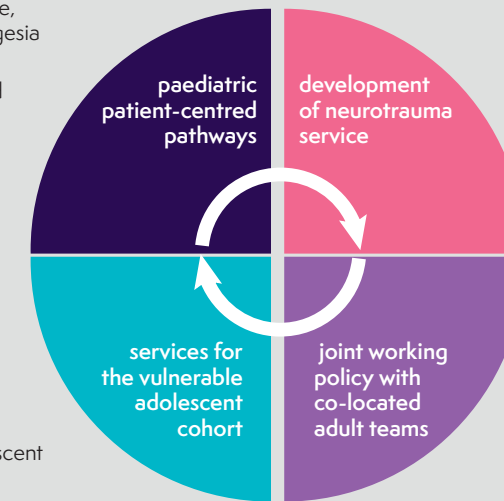
A successful bid was made to appoint a paediatric Darzi leadership fellow in 2017, followed by the creation of paediatric trauma anaesthetic and surgical fellowships in 2018. This opened the door to improved data collection, research, and service development.

1. Clinical initiatives

These are shown in Figure 1 below:

Figure 1 RLH Service developments 2017–2020

- Dedicated paediatric pathways developed for major haemorrhage, serious head injury, regional analgesia and interventional radiology
- Standardisation of equipment and paediatric-specific protocols



- Increased violence-related adolescent admissions
- Creation of a unified management team
- Injury prevention service with ongoing follow-up after discharge
- Peer working group created for adolescents with traumatic brain injury

- Previous pathway – paediatric neurotrauma requiring surgery transferred off-site (as elective paediatric neurosurgery not on-site)
- Development of a paediatric emergency neurotrauma service: enabling time critical injury management on-site
- Neurosurgical liaison with quaternary neurosurgical centres to maintain high governance standards
- Development of paediatric code-black pathway
- Three-month rotations of paediatric staff to adult theatres to gain experience in elective neurosurgery and trauma
- Penetrating trauma and major haemorrhage are more frequently seen in the adult setting
- This enables case management in adult or paediatric theatres depending on staff skill mix, availability of theatre, age and injuries of child
- This reduces time to intervention

2. Educational initiatives

Novel simulation and lecture-based trauma courses have been developed to support clinical developments.

The Paediatric Theatre Team Trauma course (PTTT), aimed at healthcare assistants, scrub staff and anaesthetic practitioners, is a one-day course of theoretical lectures, expert-led skills stations and simulation scenarios. It targets time-critical trauma emergencies encountered less frequently in paediatric practice. Feedback from participants report increased knowledge and confidence; staff non-technical skills, including communication and situational awareness, have improved. Theatre staff participants are now invited to teach new staff members on the course to consolidate and maintain skills. Rotations in adult theatres, including emergency and neurosurgical lists, have developed transferable skills and expertise.

The Paediatric Advanced Trauma Skills and Simulation course encompasses a multidisciplinary two-day course of small group discussions and simulations.

3. Research and quality improvement

Principal projects since 2017 have reviewed and standardised care across the entire London network. The Pan-London Paediatric Trauma Guidelines were published in 2020 following a review of literature to provide evidence-based best-practice guidelines.³ This provides a gold standard of care across the network.

The Paediatric Evaluation of London Trauma System (PELoTS) project reviewed care across the London Trauma System from 2018 to 2019. This provides a quality-of-care assessment and shows the burden of children's trauma and outcomes across the LMTS. A substantial proportion of presentations are self-referrals bypassing normal pre-hospital triage systems. The quality-of-care

assessment showed that trauma units would benefit from additional support in the management of paediatric trauma.

Conclusion

Current research is focusing on paediatric outcome measures and the creation of novel trauma-scoring systems specifically for paediatrics.

Substantial work has seen transformation of the paediatric trauma service from conception to clinical practice.

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- 2 Jones S *et al.* Patterns of moderate and severe injury in children after the introduction of major trauma networks. *Arch Dis Child* 2019; **104**(4):366-371.
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COMPASSION THROUGH THE COVID-19 CRISIS

Recent years have seen a drive to improve the wellbeing of doctors, particularly trainees, yet burnout and low morale extend across the NHS workforce.¹ As the system comes under unprecedented pressure to do more with less, all healthcare staff are at risk, particularly recently with the coronavirus pandemic.² How we deal with these issues is paramount to securing the future of our NHS workforce.

The Royal London Hospital Theatre Wellbeing Project is a grass roots, multidisciplinary initiative. Started in 2018 by two consultant anaesthetists, it aims to provide a multifaceted approach to improving wellbeing at work. The hospital is a major trauma centre, and in the preceding two years, theatre staff had witnessed three major incidents and the suicide of a much-loved

colleague. In an attempt to reduce the psychological distress of staff exposed to such incidents, the project was born.

Initially, the project focused around wellbeing sessions on our departmental audit day. Theatre staff rotated through themed sessions, sharing experiences, and learning proactive techniques to deal with stress. 'Coffee Club', an experiential

exchange peer-support session for anaesthetists in training, became the next success story. These meetings offer facilitated discussions where trainees share experiences or discuss wellbeing-related topics. The sessions run fortnightly during protected teaching time, and follow Chatham House rules. They are not aimed at problem solving, but rather



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at acknowledging the potential psychological impact of events we witness.

The coronavirus pandemic presented a new challenge, and with it came concerns that staff would experience emotional strain and moral injury as never before.² Seventy-five theatre staff were redeployed to the intensive care unit, anaesthetists in training were dispatched to procedural teams and temporary ICUs, and the entire department's working pattern changed overnight. Staff no longer worked in their normal teams and lacked their regular safety network. It was clear that extra support would be needed after the peak to reduce the psychological impact of the event.

Supported by management, a small wellbeing team enlisted the expertise of several trust psychologists and constructed a programme of wellbeing-related activities. On 6 May, as numbers of COVID-19 patients declined and staff began returning from redeployment, the first session opened to all theatre staff.

The protected sessions take place daily for 30 minutes before theatres start. A psychologist provides various mindfulness and relaxation sessions while colleagues reflect over breakfast provided by the trust. Theatre nurses, surgeons, healthcare assistants, and anaesthetists in training all partake together. Baseline questionnaires were distributed to survey levels of work-related stress, previous access to wellbeing resources, and development suggestions.

Following feedback, breakout sessions were introduced with smaller groups, tailoring sessions to different people's requirements. Once weekly, three breakout sessions run simultaneously. Mindfulness remains, but the addition of morning yoga, led by a generous colleague, has proved hugely popular with up to 20 attendees per session. A breakout experiential exchange session specifically for theatre staff now also runs, supervised by a clinical psychologist, while our regular Coffee Club for trainees has continued on alternate days throughout the pandemic. Anxiety surrounding coronavirus, PPE, and personal safety has proved high, and the sessions have attempted to alleviate feelings of uncertainty and loss of control. Overall, they provide a safe space for staff to reflect, while providing tools to nurture a kinder and more inclusive work environment.

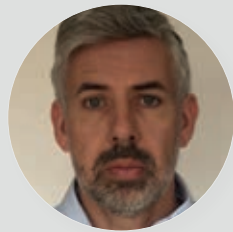
Formally capturing the impact of wellbeing interventions is notoriously difficult, but evidence comes from the numbers attending – an average of 50 attendees per day. These moments of quiet calm reach beyond the immediate theatre team to the wider multidisciplinary network. Staff feedback is unanimously positive, with sessions scoring 4.7 out of 5 for enjoyment, and eliciting multiple unsolicited 'thank you' emails. Importantly, when asked whether the sessions have improved their ability to cope with stress, staff score them 4.5 out of 5, describing them as 'powerful', 'calming', and 'amazingly helpful'.

The daily sessions are continuing for the foreseeable future, with plans to expand the activities available. We hope that, with time, they'll become a natural part of our work environment. With increasing NHS pressures not expected to subside soon, morale is likely to suffer without increased support. We must continue to improve access to wellbeing resources for all staff, displaying compassionate leadership in times of crisis and ensuring a positive, caring and supportive climate.³ This will foster greater staff wellbeing and ultimately better patient care.³ As our project continues, the feedback of one staff member stands out as key: 'Thank you; this is making a real difference.'

Many thanks to Polly Fitch, Joy McInnes, Shreya Bali, and the wider wellbeing team for their continued help with this initiative.

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A practical guide to improving teleconferencing

Teleconferencing, webinars and remote educational events have become a regular feature of the anaesthetist's working-life during COVID-19, not to mention an increasingly useful means of communication between socially-distanced patients, relatives and clinicians. However, technical issues impairing audiovisual (AV) quality can significantly impact on effective communication. As a former audio professional I can happily report that some simple changes can vastly improve things for no additional expense!

1 Technical

Conferencing applications span a variety of platforms. Insufficient processing power and internet bandwidth are common causes of problems regardless of device or software. These aspects are easily optimised.

Increase processing power

- Use the most modern device available to you.
- Quit all unnecessary applications.

- Close all unused browser tabs and windows.
- Clear your internet browser cache and delete cookies.

Maximise bandwidth

- Connect directly to your router using an ethernet (Cat 5) cable.
- Powerline adaptors can help extend wired ethernet connectivity in installations where direct connection is impractical.
- If you must use Wi-Fi stay in line of sight of the router with minimal obstacles between it and you.
- 5Ghz Wi-Fi provides the highest bandwidth (at the expense of lower signal strength and penetration).
- Disconnect all other devices from the Wi-Fi network.
- Choose an uncongested local Wi-Fi channel (bit.ly/2YE2NUV).
- Reduce traffic: dissuade others from internet use while on a call at home.

2 Audio

The loss of natural psychoacoustic cues during the telecommunication process reduce intelligibility, comprehension and recall.^{1,2,3} Capturing high-fidelity source audio is vital. Modifiable variables include acoustics, environment, and generated noise.

Acoustics

The pickup characteristics of in-built microphones plus an untreated acoustic environment combine to hamper intelligibility. Key improvements include choosing the appropriate environment, increasing the ratio of direct to reflected sound and using an alternative microphone.

- Stay at least 1m from walls.
- Select a reasonably-sized room with non-parallel walls (where possible). If this geometry isn't feasible orient yourself along a diagonal with your back to a corner to reduce troublesome reflections, flutter echoes and audio colouration.
- Minimise reverberation by choosing a carpeted room with plentiful soft furnishings.
- Avoid areas with extensive tiled, glass or hard reflective surfaces.
- Sound intensity varies with the square of distance: move nearer the microphone to increase the balance of direct to reflected sound.
- Use a headset with integrated microphone (try the one provided with your mobile phone).
- Use a stand-alone unidirectional microphone (but avoid getting closer than 15cm).

Environment

- Choose a quiet indoor location.
- Close all windows.
- Be alert to background noise within the room.
- Maximise the distance between yourself and other noise sources.

Generated noise

- Type with a remote keyboard.
- Be alert to transmitted noise and vibrations through furniture.
- Take care if using notes: rustling paper sounds particularly disagreeable when broadcast and amplified.

Feedback

Audio feedback is an unpleasant screeching sound produced when a microphone picks up its own amplified signal. To control feedback:

- reduce microphone input level (gain)
- reduce loudspeaker volume
- increase the distance between microphone and loudspeakers
- orientate the rear of any unidirectional microphone towards the loudspeakers
- use a headset.

3 Visual

Modern camera technology is excellent. High quality source material makes the best of its capabilities.

Lighting

- Ensure your face is adequately illuminated.
- Daylight is an excellent diffuse lightsource.
- Sit facing directly towards a window (north-facing windows prevent harsh shadows caused by direct sunlight). Turning slightly off-axis adds depth to your image.
- Avoid strong light sources behind you.
- A diffuse lightsource aimed at the backdrop minimises cast shadows (as will staying 1m from the wall).

Camera

- Activate high definition (HD) video where possible.
- Elevate the camera to eye level and address it directly.
- Compose the shot with your eyes

on an imaginary horizontal line one third of the way down from the top of the screen.

- Check the composition for framing, straightness and gestalt (plants growing out of your head etc).
- Slight movements are exaggerated: mount your device on a stable surface or use a tripod.

Background

- Check what is behind you in shot.
- Background clutter disrupts your outline and competes for attention.
- Neutral, light-coloured backgrounds (without patterning) focus attention on the speaker.

Conclusion

Simple changes can vastly improve the teleconferencing experience without needing to add an AV Technician to the on-call rota!

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Pop-up simulation suite utilising Zoom videoconferencing

The coronavirus disease (COVID-19) pandemic has had a significant impact upon educational opportunities. One of the groups of anaesthetists in training most disadvantaged by this have been novice trainees working towards achieving the Initial Assessment of Competence (IAC).

Factors that have limited airway-management training opportunities include:

- redeployment to cover critical care surge rotas
- cancellation of elective operating lists
- performance of procedures under regional anaesthesia to reduce aerosol generation
- guidelines advocating minimising the number of people in theatre and intubation by experienced anaesthetists
- cancellation of courses and temporary closure of resources such as simulation suites.

To address this training deficit, we produced an in-situ simulation teaching programme mapped to the IAC. Simulation is a well-recognised method for the delivery of education and training, as outlined in the RCoA Simulation Strategy.¹ It has played an important role during the COVID-19

pandemic, providing a safe environment in which to test the preparedness of healthcare workers and systems.²

In order to maintain social distancing during the sessions, we were keen to explore methods to recreate a typical audiovisual set-up as found

Figure 1 Suggested configuration for audiovisual device

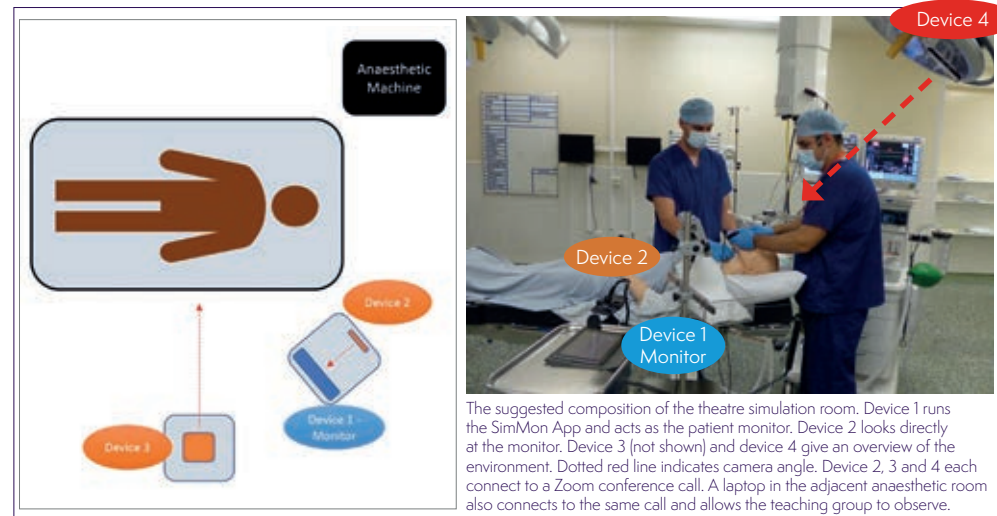


Figure 2 Gallery View of Z-Sim



in fixed simulation suites. As a department we were already using Zoom videoconferencing for regular departmental updates, and we hypothesised that with minimal set-up time and expenditure such software could also be used to recreate a mobile audiovisual simulation-suite environment.

We have now run two such sessions for the novice trainees, one on rapid sequence inductions and the other on failed intubation management. Feedback has been very positive, with trainees reporting improved confidence and highly valuing the opportunity to train in a real theatre environment. Larger numbers of observers, and even remote access from home, could be accommodated. It may also provide opportunities for members of the multidisciplinary team who have been avoiding face-to-face patient interactions to safely maintain their skill set.

Utilising existing equipment and free videoconferencing software, it is possible to create a 'pop-up' audiovisual simulation suite for in-situ training in a matter of minutes. The ability to view remotely improves scenario fidelity and enables multiple healthcare workers to train while maintaining social distancing.

To create your own pop-up simulation suite you will need:

- standard in-situ simulation-session equipment (mannequin, airway equipment, etc)
- at least three smartphones
- one tablet computer
- one laptop (large screen preferable)
- Wi-Fi/4G signal
- Zoom software
- SimMon Medical Simulation app or equivalent
- variety of stands/grips/chest-mounted smartphone harness (optional)
- external microphones (optional).

Set-up (allow 5–10 minutes)

- 1 Set up mannequin and equipment as for standard in-situ session.
- 2 Pair SimMon Monitoring app on smartphone and tablet.
- 3 Set up cameras (see Figure 1 for suggested configuration).
- 4 Set up Zoom meeting on laptop in remote location.
- 5 Log devices in steps 2–4 into Zoom meeting.
- 6 Trainee is briefed and then enters simulation room – remaining trainees observe on laptop in Gallery View (See Figure 2).

HINTS AND TIPS

- explain audiovisual set-up and confirm that trainees are happy to participate
- ensure all devices are charged and bring additional chargers/battery packs
- perform sound check
- ensure adequate soundproofing between simulation location and remote location
- only have one microphone turned on in simulation room (mute others)
- you can temporarily unmute microphone on laptop to simulate 'Voice-of-God'
- a chest-mounted smartphone provides a first-person view with improved audio quality
- Zoom meetings can be recorded and footage can be incorporated into the debrief (seek prior permission).

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TRAINING OUTSIDE THE BOX

When exam issues meant I had to take a year’s break from training after CT3, I thought hard about what to fill the next year with. I was encouraged to continue on the general duties rota, but after a stressful year I felt I needed to step out of that and gain some different experience. I wanted to face something that scared me.

As is the case for many of us, sick children terrified me more than anything else that the emergency bleep could throw at me. At that point I found a vacancy for a junior fellowship in paediatric retrieval and intensive care medicine and applied for it. Despite being an anaesthetist and not a paediatrician, I got the job. My anaesthetic consultant colleagues had a mixed reaction; a minority felt it was a waste of time.

I was initially very nervous; I had no general paediatric experience and only core paediatric anaesthesia competencies. However, I was assured that the skills I had from core training in anaesthetics and intensive care medicine would come in handy. That didn’t stop imposter syndrome overshadowing the first six months though!

The Job

As anaesthetists we know the importance of checking equipment and being intimately familiar with its use. On transport this is even more important – you can’t just ask for your nurse to grab something because you don’t have it nearby. We undertake twice-daily checks of the equipment, including trolley, ventilators, syringe pumps, suction, and kit bags. Any problems are sorted, or are reported at handover along with traffic, weather and logistical issues.

We then await a referral. Some calls are just for advice, but a majority require us to retrieve a child, which can mean anything from a 2 kg baby up to an 18-year-old. Their presentations range from bronchiolitis and congenital cardiac conditions, to those that we are more familiar with in adults, such as significant overdoses and cardiac arrests. After ensuring we have the correct equipment for the patient, we travel via ambulance to the referral hospital.

On arrival at the referral hospital we take handover and assess the child, performing any additional procedures or investigations that are necessary to safely transfer them. This can include things like intubation, lines or imaging. We then ‘package’ the patient and take them to a regional paediatric intensive care unit (PICU) for further care.

After travelling back to base, cleaning the equipment and completing paperwork we await another referral.

As with any job, audit, education and things like morbidity and mortality presentations fill the rest of the time. I also spent some shifts on the PICU, which provided further crucial experience in a less time-critical and isolated environment.

Challenges

Although managing the airway, breathing and circulation is ‘what we do’ as anaesthetists, paediatric intensive care medicine is a different game to its adult cousin. For example, fluid management is much more tailored and precise. Drug dosing and infusions are obviously a challenge but aide-memoires and an experienced PICU nurse make things much easier! The biggest challenge that I found as an anaesthetist was a lack of general paediatric knowledge, for example of metabolic conditions that we just don’t see in adult practice. However, these problems are usually ones that can be managed after a phone call for advice; managing A, B and C can’t wait! Consultant support has been solid and, although often many miles away, is always forthcoming and enthusiastic.

Disadvantages

Deskilling is an issue; however, the experience gained is useful for the rest of your career. Like trainees who take a year out of clinical practice for research, parental leave, etc, you are able to access return-to-work days, and I have found my anaesthetic colleagues have welcomed my return.

COVID-19

Being out of anaesthetic practice during COVID-19 has been both a blessing and a curse. I do feel that I missed out on significant experience by not being there to help my colleagues. I did spend some shifts on ITU during the pandemic, but nowhere near as many as I would have done. Paediatric transport had its own challenges, and I helped develop protocols and deliver simulation and training for the transport of suspected COVID-19 patients.

Summary

Although an unusual choice of fellowship, working in paediatric intensive care medicine/retrieval is a very useful experience for those interested in either paediatric anaesthesia, or in careers where stabilising unwell children will be part of their job, such as intensive care medicine in some district general hospitals. Approach your local team (every area is covered by one) and ask if they have any vacancies coming up.

For those thinking of gaining experience ‘outside the box’, I would encourage you to go for it. Gaining more experience in a field that interests you will never be detrimental to your career and will be looked upon favourably by those employing you in the future.

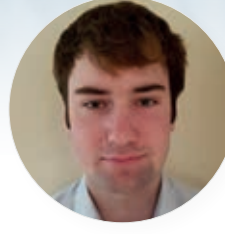
Gaining more experience will never be detrimental to your career

'IT'S JUST LIKE FLYING A PLANE'

How one tertiary centre collaborated with the aviation sector to provide simulation training to staff working during the COVID-19 pandemic.



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Henry Walker
Pilot

At the beginning of the pandemic, St Georges Advanced Patient Simulator (GAPS) set up a COVID-19 boot camp. We upskilled approximately 800 members of staff, from foundation doctors to consultants, who were redeployed to acute medicine from diverse specialties ranging from clinical genetics to dermatology.

We wanted to reintroduce staff to assessment of medical patients, and to encourage them to think about early treatment escalation planning. This was achieved via a simulated board round. Teams were then encouraged to allocate roles, before being asked to review two patients in a simulated acute medical unit.

Further learning revolved around personal protection equipment (PPE). The simulation centre demarcated clean and dirty zones, and simulation scenarios necessitated participants donning non aerosol-generating-procedure (AGP) PPE, before doffing this to put on full AGP PPE.

Prebriefing and debriefing occurred before and after scenarios. Fruitful discussions emerged, and these regularly focused around non-clinical aspects of tasks. Communication and team working in unfamiliar environments with uncomfortable PPE, were frequently touched upon.

Pilot, Henry Walker, explains here how our aviation colleagues developed our thinking in new ways –

It was not long after this pandemic started that I found myself grounded along with most of my peers. Immediately a call for volunteers came through, initiated by a couple of captains from EasyJet and British Airways who had ties with the medical profession and who realised how useful their skillsets could be to the NHS. They set up a charity called Project Wingman, with the aim of creating a rest zone in the middle of hospitals for all staff from cleaners to consultants. The idea was to draw on the experience of airline crew, who regularly find themselves in stressful situations, to

provide sympathy and pastoral support to stretched NHS workers. I signed up as soon as I could and was allocated to St George's Hospital, Tooting.

One month in, having made connections with the educators at the simulation centre, we were invited to observe a COVID-19 boot camp simulation session for F1 junior doctors.

This was the first time I had ever witnessed a medical simulator session, and some interesting things became apparent. Whichever way you look at it, flying a plane has little in common with a medical procedure on a technical level, so the area of interest to me was what we call 'non-techs', essentially the human performance element – team work, leadership, and workload management. In aviation we are all carefully trained in these disciplines, because when you are working with one other person on the flight deck it is crucial that you form a tight-knit team. This is easier to achieve when there are only two people present. Watching six F1 doctors in a session

The area of interest to me was what we call 'non-techs', essentially the human performance element

working together was very interesting, as many of the skills needed for success directly transfer between the two fields. It was amazing to be able to feed back a few points on the day to the doctors involved and to see how these skills, which people don't necessarily realise they possess, can come in handy in a totally different environment.

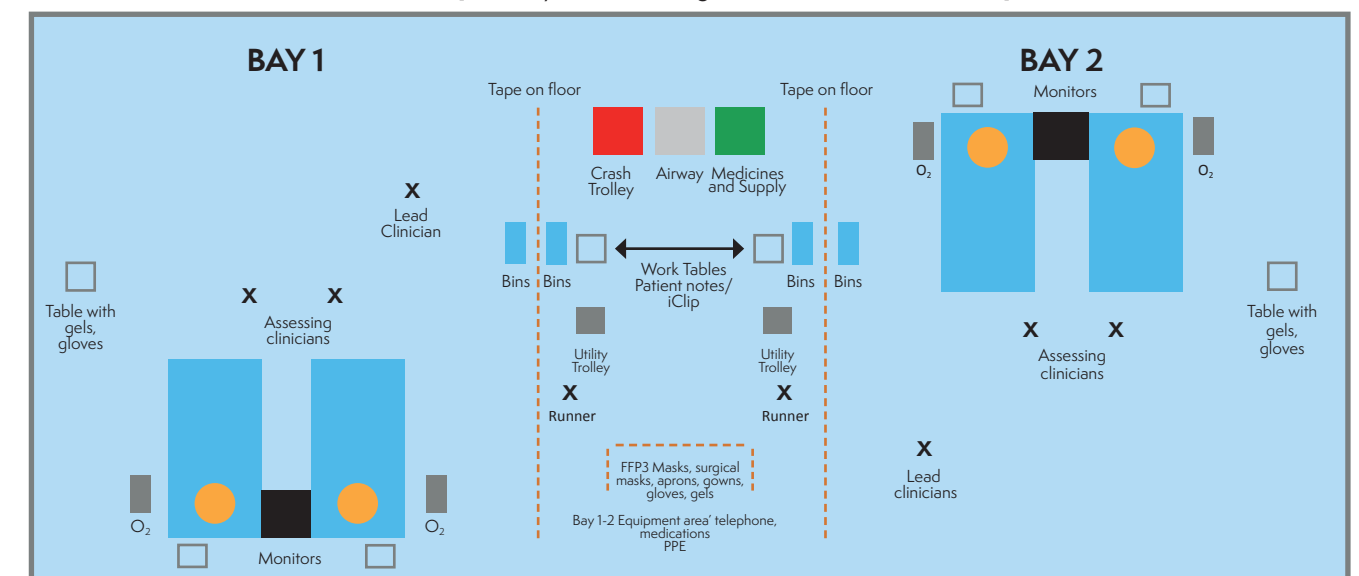
After the success of the simulation session, a round-table discussion was held a few weeks later involving two of us flight crew and some staff from a number of different hospital departments to discuss the overlaps in our industries. This time we focused on the attitude to safety in our respective workplaces, with the discussion ranging from accountability to how we mitigate risk. Aviation has a long history of briefing – after all, to be forewarned is

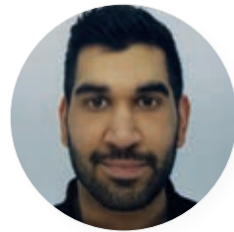
to be forearmed! Our work day starts with a briefing, and we hold update briefings as the day goes on: every take off, landing or approach will always be pre-discussed. This means that both of us on the flight deck are aware at all times of what is expected to happen, and are therefore more likely to pick up on any deviation from the plan that may occur. I remember this was particularly interesting to some ward staff who had recently implemented a more formal handover discussion at the change of every shift. The conversation then moved on to other areas of similarity, particularly the growing use of checklists in medicine, a staple of the aviation world. The final topic of discussion was what we call the hierarchal gradient, and the concept of even the most junior member of a team being able to speak up to their leader without fear. This

has proved vital in aviation, as many incidents could have been avoided in the past if junior crew members had been prepared to speak up. It was encouraging to hear how the medical profession continually strives to promote open channels of discussion so that no one feels scared to speak up, even though it may take real courage to do so.

In all, Project Wingman has been a fascinating experience for me over the last few months. I never realised how such different workplaces share so many of the same challenges, and how processes often developed through necessity in the aviation sector are finding new homes and bringing improvements to the medical sector.

Figure 1 Simulation room layout showing 'clean' and 'dirty' areas indicated by the dotted lines and with labelled equipment. Xs represent possible locations of the clinical team during a 'ward round' (usually 3 or 4 staff) with the 'runner' in the 'clean' area of a COVID-19 Acute Medical Unit. [Courtesy of Huon Snelgrove, Educationalist at GAPS]





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Meghana Pandit Safety Fellowship: patient-safety perspectives in a different healthcare system

Development and mastery of technical skills is emphasised throughout training – for example, an unexpected difficult airway, obstetric emergency simulation and advanced resuscitation and trauma management. However, problems continue to arise as a result of failings in human interaction, behaviours, and team-working ability. Furthermore, the World Health Organization (WHO) estimates that 50 per cent of cases of patient harm within hospital care are wholly preventable.¹ These non-technical skills need work, with a shift in the culture away from individual blame to a focus on patient safety to foster a system of learning.

Working at University Hospitals Coventry and Warwickshire (UHCW) during my ST4 year offered a different perspective to training. Alongside my conventional training needs, I was exposed to a way of thinking geared towards looking at the bigger picture of healthcare provision. In 2015, UHCW was selected by the then Trust Development Authority (now NHS Improvement) as one of five hospital trusts to partner with Virginia Mason Institute (VMI) in Seattle.² Having been through its own difficulties, the VMI developed the Virginia Mason Production System as a means of empowering staff to identify potential issues within the patient pathway. Through the concept of Lean principles, a culture of continuous

improvement was developed to identify wasteful processes, drive change, and learn from errors.

In December last year, I was successful in an application to the 'Meghana Pandit Safety Fellowship – UHCW', a bespoke two-week programme based at the Beth Israel Deaconess Medical Centre (BIDMC), Boston, US. The first week involved a formal Quality Improvement Week held for the anesthesia interns, conducted by members of the managerial team and the department of anesthesia. Human factors principles, organisational structure, hospital financial systems, and the methodology for conducting a root cause analysis (RCA) were introduced. The week culminated with lessons on

design theory, ensuring interventions generated by RCAs remain successful and are integrated within the system.

Although we have a mandatory annual expectation of involvement in audit or quality improvement (QI) within the UK, there is little or no formal teaching on how to undertake this. During anesthesia residency training (three years) at BIDMC, doctors are expected to be involved in only one project, but conduct a RCA and generate a high-quality change or intervention. Formalised training with an opportunity to learn and develop in the field of QI is unique, and BIDMC feel that this is how they can foster a culture of continuous improvement.

During the second week, I spent time in the operating room (OR) environment.



Despite some noticeable differences in the perioperative pathway, the underlying essence of patient care and provision of treatment was the same as in the NHS. However, there were aspects of anaesthesia that were different and offered a degree of improved patient safety. Omnicell drug-storage units were present in the OR enabling the anesthesiologist to have personal control of their drug inventory. Operative events were recorded seamlessly onto an electronic patient record, and there was a convenient option to report safety incidents, following which all the information would be immediately available to the safety team. Mortality and morbidity meetings presented a full RCA of each patient-safety incident, which highlighted system failures and weaknesses that could have been instrumental to the event. As a result, there was a greater buy-in to the proposed solutions and a shared appreciation of pitfalls within the current set-up.

It would be naive of me to ignore the impact that billing and financial revenue had upon development of these strategies. Ultimately, focusing on

safety helped minimise variability thus maintaining efficiency, particularly in a system with a close eye on the bottom line. The link between safer care and lower costs was more obvious in the American healthcare setting than in the UK's, where the provider sits some distance from the financial implications of healthcare provision.

The fellowship offers a wide scope for improving the principles of delivery of safe care that we employ in the UK. The NHS and the College have some particular advantages through nationwide sharing of knowledge (National Audit Projects, National Emergency Laparotomy Audit) and objective assessment of current practice (Care Quality Commission), which contrasts with the silo approach seen in American healthcare. However, it is essential to encourage an open and transparent environment in which completing an incident form isn't seen as a reflection of bad practice, but more as an opportunity for growth and improvement.³ In order to change we need to be able to empower all members of the team to contribute,

and to flatten the hierarchy and disseminate learning.

I would like to extend my thanks to Professor Meghana Pandit (Oxford University Hospitals) for the opportunity that was created while she was Chief Medical Officer at UHCW, and also Warwick University, BIDMC, and Harvard Medical School. In addition, I am grateful to Dr Sailesh Sankar (Director of Medical Education, Warwick), Dr Satya Krishnan Ramachandran and Dr Cullen Jackson (BIDMC) for their help and guidance throughout the programme.

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Lancashire Teaching Hospitals NHS Foundation Trust (LTHTR) Simulation team



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'New to the NHS' national MTI simulation programme

The Medical Training Initiative (MTI) is a national scheme designed to allow a limited number of international medical graduates (IMGs) to work in the NHS for a maximum period of two years before returning to their home countries.

MTI doctors will benefit from world-class clinical training, and also develop non-clinical skills, such as medical education and leadership, which will benefit not only the individual doctors, but also the healthcare systems and patients in their home countries.

The Royal College of Anaesthetists manages the MTI scheme for

anaesthesia, intensive care medicine and pain medicine through their Global Partnerships team.

Background

As IMGs come from various cultural backgrounds, their major challenges are to adapt to British culture and integrate into the NHS. IMGs tend to require extra support from their UK

hospital in the following areas: dealing with medical emergencies, protocols/guidelines, and non-clinical skills related to communication and interpersonal skills, social and cultural issues, NHS work culture, end-of-life decisions, confidentiality and consent.¹

Simulation activities followed by debriefing are a powerful form of

enactive experience to facilitate reflection, learning, familiarisation, and connections to real events, with growing evidence for their use in medical education.²

Previous experience

In 2017, I started the simulation-based human factors, communication and critical incidents course for IMG doctors at Lancashire Teaching Hospitals NHS Foundation Trust, with support from our simulation lead Dr James Wilson. Various factors contributed to the successful establishment of this course – my knowledge of the IMGs' medical training programmes in their own countries (including cultural/clinical aspects), and Dr Wilson's previous experience on simulation training. A survey of all the IMGs who attended the course showed marked improvements in various aspects of communication, familiarisation with the NHS, and team working.³

Medway NHS Foundation Trust runs a similar simulation-based induction for IMGs, which is conducted by Dr Ruwanmali De Silva. Their course significantly reduced agency locum spends by early integration of IMGs into the NHS, building familiarity with policies/protocols, and training in human factors, and communication and interpersonal skills. Their first five-day course was highly commended

in the *British Medical Journal* awards 2019 and shortlisted for the *Health Services Journal* value awards. Medway runs the only two-day course in the programme.

The team

Dr De Silva and I firmly believed that establishing national simulation courses tailored to the needs of MTI doctors would benefit this cohort. We took our proposal to the RCoA and its MTI leadership group, who were supportive. We identified trusts around the country that had the capacity and were interested in running a similar course. Of the interested centres, we had to select those who were geographically well spread so that MTI doctors across the UK can widely access the courses. With our support five centres have been set up as outlined in Table 1.

The course

The centres have the option of running a one-day or a two-day course (they can apply for CPD points from RCoA), depending on their previous experience and the resources available. Topics to be covered, with the intended learning outcomes for standardisation of the course, have been agreed. These include familiarisation with working in the NHS, communication and interpersonal skills, human factors/situational awareness, and critical incidents related to anaesthesia/intensive care. Comprehensive pre-course

For more information about the MTI programme please visit our website at:
rcoa.ac.uk/medical-training-initiative

reading material is also provided. An observer for each centre, either from the RCoA Global Partnerships committee or the MTI leadership group, both for support and quality assurance, has been proposed. We have so far run two successful courses of this programme, and feedback received has been very positive and encouraging. More information on the centres, including the dates of future courses, can be found at: bit.ly/RCoA-MTI-UK.

Plans for the future

The simulation course is primarily for MTI doctors. MTI numbers are increasing every year (112 in 2019 compared to 43 in 2014). In coming years we may require more centres to help us run this programme to meet the existing demand. Providing that we manage to increase capacity, we may be able to offer places to other IMG doctors in anaesthesia and intensive care medicine.

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- 1 Hashim A. Educational challenges faced by international medical graduates in the UK. *Adv Med Educ Pract* 2017; **8**:441-445.
- 2 Hing Yu So *et al.* Simulation in medical education. *J R Coll Physicians Edinb* 2019; **49**:52-57.
- 3 epostersonline.com/soa2019/node/827?view=true.

Acknowledgement

We would like to thank David Calderon-Prada, Global Partnerships Administrator, RCoA for all his support in setting up this programme.

AN INSIDER'S VIEW

Associate Professor Helen Higham
 Consultant Anaesthetist,
 John Radcliff Hospital, Oxford
helen.higham@ndcn.ox.ac.uk



WHY BECOME A COLLEGE EVENT SPEAKER?

More than 1,700 of our fellows and members selflessly contribute their time, energy and skills enthusiastically to the work of the College. These roles range from examiners, to committee members, to ACSA leads.

In this issue, we have Professor Helen Higham, a consultant anaesthetist, from the John Radcliff Hospital in Oxford. She is one of our wonderful regular contributors to events at the College. Please read on for an edited version of the interview with Professor Higham, recorded in June 2020. To listen to the full interview, visit our website at: rcoa.ac.uk/insiders-view-why-become-event-speaker

Please tell us a bit about yourself. Did you have previous event-speaker experience?

As well as being a consultant anaesthetist in Oxford, I am the director of our simulation centre. I have a long-term interest in education, and have been teaching and speaking at events ever since I was a registrar. So, it felt perfectly natural when my wonderful long-time mentor and supervisor Professor Pierre Foëx, invited me to speak at the College at a cardiac risk symposium. That opportunity was my first foothold, and since then I've also done work in the 'train-the-trainer' area, some human factors work, and lectured at the 25th anniversary celebrations, which was a really nice thing to be able to do.

What was your lecture for the 25th anniversary?

It focused specifically on the role of anaesthesia in the development of human factors training in healthcare. I'm proud that as a profession we've been at the forefront of those developments. We wrote an article about it for the journal which really crystallised some of the things I felt strongly about regarding what we deliver, not just in our clinical work, but the extent of what we do in patient safety (bit.ly/2EwVG9F).

You mentioned having a mentor. Have you considered or are you already mentoring others?

We've had a mentorship programme for new consultants for a while now in Oxford. When I arrived, I nominated my own mentor. This was someone I had admired as a trainee and a research fellow, consultant anaesthetist Matthew Sainsbury. He was a tremendous support to me in my early consultant career. I think the mentor has a vitally important role when you're beginning your career. There are all sorts of issues and concerns which may not be things you think about initially

when you start your job. I currently mentor two of our consultants. We make sure that the pastoral side of care for new colleagues is addressed pretty robustly. In the current extraordinary COVID-19 circumstances, it's become very evident why those mentorship roles are so important.

Can you share any experiences, professional and personal learning, or skill-sets that you have gained through your work with the College?

It has reinforced the importance of good educational design for me. There are a number of things that are involved in delivering a really good learning experience. I would like to stress the importance of good infrastructure, communication, and administration for any of the teaching activities. I think the College really has that nailed now. We feel very supported when we're running an event, which is especially important as you are usually setting things up from a distance. Many attendees are also coming from quite a distance, therefore the College looking after people – making them feel welcome



and thinking that it's worthwhile – is very important. In all honesty, it is part of the reason that you get good feedback – it's when things are run well, people connect well and are communicated with.

What are important qualities an event-speaker should have?

I've taken a further qualification in adult education, and what that does is really clarify the way that you design and deliver the educational experience. Of course, that starts with defining what your learning outcomes are. Alongside that, is the importance of a careful choice of faculty, and understanding the format in which you are going to deliver this learning experience.

I think there are three key factors regarding choosing faculty for an event. The first and foremost is expertise. Secondly, you need someone who can deliver the content of their talk well – entertaining as well as having a clear direction – and who is comfortable interacting with the people in the room. The third, I would suggest, is a good sense of humour. I think people

really enjoy a member of faculty who is keen to inject some sense of levity into the proceedings. It really helps with attention and with engaging people as well as encouraging attendees to speak to you after you've finished speaking.

Can you share your most interesting experience from your time as an event-speaker so far?

I wouldn't say that there is any one particular thing that stood out, but it's more that when you are sitting in a room and the whole audience is either smiling or laughing with the presenter, you know you've got them engaged and that they are likely to take something useful away from the session.

Hopefully, this interview will encourage more people to come forward and think about becoming an event-speaker.

Absolutely. I believe people need to be encouraged by realising that the College is a welcoming place, that it is easy to engage and get involved, and that they should feel very comfortable doing that.

I've got one last question for you: if you could give one piece of advice to someone thinking about becoming an event-speaker what would it be?

To be honest, it is to just do it and to contact the College. There will no doubt be someone in your hospital that is already doing this. Go and talk to them 'What is it like?', 'How do I do it?' And certainly don't be afraid, just do it.

Since the interview, Dr Helen Higham has been made an associate professor. We would like to wholeheartedly congratulate her on this achievement.



For further information, please visit the Get involved section of our website: bit.ly/RCoA-Involved



AS WE WERE... HAPPY EVER AFTER

*'The years go by, as quickly as a wink
Enjoy yourself, enjoy yourself, its later than you think'*
Herb Magidson, 1949

Six months ago, 'As we were' offered the thoughts of David Bogod as he retired. We both demitted College Council on the same day, but I left anaesthesia a year before him, also with 39 years on the clock. The invitation to follow him in reflecting on a career leaves me wondering what can I add?

The backdrop to 'As we were' in 1980 was, as now, a troubled Britain. Inflation was at 21%, the economy shrinking by 4% annually, unemployment at 1.5 million, riots in Bristol, a female Conservative prime minister who

was 'not for turning', and an ageing Labour party leader whose dress at the Cenotaph was judged improper. We drove the new Austin Metro, were self-sufficient in North Sea oil, and watched the launch of 'Yes Minister'

and 'Newsnight'. Elsewhere in the world, smallpox was pronounced eradicated, Iraq declared holy war on Iran, while presidents Carter and Brezhnev continued the Cold War. Rishi Sunak was born, John Lennon died, and amazingly



Dr Janice Fazackerley
Associate Medical Director for Medical Appraisal,
Warrington and Halton Hospitals
JFazackerley@rcoa.ac.uk

Nottingham Forest retained the European Cup (Champions League).

Meanwhile in Liverpool, I entered Walton and Fazakerley Hospitals as a novice anaesthetist and immediately loved my new job. Led by Tom Forrest, an exemplary 'administrative anaesthetist', this was a happy ship. Neither leadership and management qualifications nor wellbeing and resilience training had been heard of, but Tom was a born leader whose staff felt that he cared. We belonged, and his cheerful consistent support and encouragement, given without fear of blame or managerial interference, was a lifeline for me. By six weeks in, I was on-call alone, scared, but valued for the essential service I could now provide – with a little help from my friends the operating department assistants, whose immense ability and Scouse wit saved many a day.

The happy ship was, of course sailing in a different era to which we cannot, and should not, return. Patient outcomes, other than alive or dead, were not considered, litigation was in its infancy, the general public were deferential to doctors, and had no recourse to medical advice on the internet. Developments in all these fields are to be welcomed. Our long, dangerous and antisocial hours were tolerable only because there were sympathetic consultants, the good-humoured understanding of theatre staff, managers' appreciation of medical expertise, and a few home comforts. Waking up after on-call to the tea lady offering 'one cup or two', served in bed, or afternoon bread and jam provided in the mess, meant so

...six weeks in, I was on-call alone, scared, but valued...

much more than they ever cost the hospital. It is sad that at the end of my career, I helped the College produce the 2017 RCoA Morale and Welfare Report, which presented 'a moral and financial imperative to safeguard the health and welfare of the anaesthetic workforce', after listening to the woes of contemporary anaesthetists in training.

Despite the lack of ideal drugs and of reliable anaesthetic machines and monitors, anaesthesia in 1980 was interesting for the variety of options on offer and the challenge of providing the 'least-worst' anaesthetic. Most drugs needed perfect hepatic and/or renal function for inactivation, and had multisystem side-effects; so my technique was more cookery than science – mixing, timing, and balancing drugs like methohexitone, althesin, propanidid, fortral, gallamine, fazadinium, enflurane and trilene (ask an over-60-year-old) to achieve sleep with minimal trouble. Pain relief was optional. The re-usable rubber airway adjuncts, in black or red with ill-fitting connections and no airway monitoring, taught me from the start the importance of constant vigilance beside the patient. I must owe my sanity and longevity to propofol, sevoflurane, laryngeal masks, and disposable plastic, but mostly to fentanyl, the only drug to appear in my first and last anaesthetic.

Support for exams was provided then, as now, by day-release teaching. The

university department in Liverpool recruited novices and provided classroom training for Primary FFARCS. This was fortunate, because there was no curriculum or exam syllabus and few relevant texts. No clinical knowledge was required, simply the 3Ps: physiology, pharmacology and physics/clinical measurement. The lecture notes from Steve Snowden, Jennie Hunter and John Utting provided the sum total of my knowledge when after five months I presented myself at Queen Square, and 'satisfied the examiners'.

The purpose of 'As we were' is surely to provoke thoughts on 'how we are'. Anaesthesia in 1980 had many challenges. They were different from today's, and we never met a pandemic challenge. To recall again the 2017 College Morale and Welfare Report, Liam Brennan stated that 'anaesthesia is highly valued for its clinical challenges, team working, application of basic scientific knowledge at every patient encounter, and diverse career opportunities. It is the system in which anaesthetists work and train which is the problem'. The qualities of anaesthesia are enduring, and while we cannot solve the problems of the system, I would like to think that every anaesthetist in training is supported by a Tom Forrest equivalent on the 'shop floor', running a happy ship.



NEW TO THE COLLEGE

The following appointments/re-appointments were approved (re-appointments marked with an asterisk).

College Tutors

London

South East

Dr Rachel Addison (Princess Royal University Hospital) in succession to Dr Helen Statham

North West

Dr Neelam A Patel (Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust) in succession to Dr Paul Clements

Dr Vivek K Sinha (The Royal Oldham Hospital) in succession to Dr Joanne Humphreys

West Midlands

Stoke

Dr Vivekanand Eli (Princess Royal Hospital) in succession to Dr Saiprasad Annadurai

Dr Adilah Miraj (Queen's Hospital Burton) in succession to Dr Manab Haldar

Certificate of Completion of Training

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.

July

Barts & The London

Beki Baytug
Priya Shinde
Ching Pang

Birmingham

Charlotte Small
Joseph Seager

East & North Yorkshire

Alexander Bell
Sarah Raut

East Midlands

Nicholas Brazel
William Tomlinson
William Rattenberry
Jake Turner ^{PHEM}
Louise Potter

Amr Hassan
Deepak Choudhry
Sachin Alva
Radha Kunte
Roshan Thawale

East of Scotland

Rafiqu Shabiyulla
Naveeta Maini
Alasdair Taylor
Katie Misselbrook
James Bowness

Imperial

Jennifer Abthorpe ^{Dual ICM}
Kevin O'Donoghue

Kent, Surrey & Sussex

Shyam Laxman
Gregory Waight
Sarvesh Zope

East of England

Julia Neely
Meike Keil ^{Dual ICM}
Rachael Morris
Lisa Grimes
Daniel Stolady

Mersey

Samuel Howitt
Sarah Schofield
Diane Murray ^{Dual ICM}
Timothy Furniss
Owen Chambers

North Central London

Ravi Bhatia ^{Dual ICM}
Samuel Al-Kadhimi
Ryan Howle

North West

Gareth Kitchen
David Freeman
Matthew Smith ^{Dual ICM}

Stephen Traynor
Laura Cooper ^{Dual ICM}
Simon Bluhm
Geoffrey Ryder
Charles Cross

Northern

Rachel Horner
Michael James
Neil Hall
Mark Dalton
Abhik Guha

Northern Ireland

Nauman Iftikhar
Bronagh McKay
Matthew Grimes ^{Dual ICM}
Thomas Hargreaves
Ryan Sykes
Brian McAlary
Nathan Oliver

Oxford

Aoife Fitzgerald ^{Dual ICM}
Katie Russell
Henry Lewith

Peninsula

Gareth Meredith
Deborah Webster ^{Dual ICM}
Andrew Woodgate

Severn

Helen Williams
Rebecca Williams
James Blackburn ^{PHEM}
Matthew Kerton ^{PHEM}
David Radley
Victoria Bell
James Self

South East

James O'Carroll
Sarah Muldoon
Richard Lin

South East Scotland

Thomas Ballantyne
Elspeth Paterson
John McLenachan

South Yorkshire

Claire Cruikshanks
William Lindsay
James Turnbull

St George's

Mark Sapsford

Stoke

Mohamed Elriedy
Felicity Avann

Wales

Christopher Bailey
Craig Beaton ^{Dual ICM}

Wessex

Rachel Montgomery
Said Seifalian
Andrew Burton
Hugh Cutler
Stephen Phillips

West of Scotland

Jacqueline Harkins
Rachel Fulton
Amanda Milligan
James Small
Naveed Karim

West Yorkshire

Selin Kabadayi ^{Dual ICM}
Roshan Rao
Omar Jundi ^{Dual ICM}

August

Birmingham

Miriam Namih

Defence

Matthew Boyd

East Midlands

Lohita Rilesh Nanda

Imperial

Jonathan Breeze
Hoi Wong

Mersey

Duncan Hughes

North Central London

Girish Narasimha Murthy
Stefan Sevastru
Vivienne Hannon

North West

Essam Abul Magd

Northern Ireland

Caroline Martin
Diarmaid Dillon

Oxford

Anna Petsas ^{Joint ICM}
Michael Holland

Peninsula

Deborah Sanders
Shelley Barnes

South East

Nicholas Dodds ^{Dual IC}
Mitul Patel
Simon Fitzgerald
Thomas Atkinson

South East Scotland

Jonathan Hetherington

South Yorkshire

John Bramwell ^{Dual ICM}

St George's

Emma Tyson
Thomas Girdler-Hardy

Wales

Lalindra Bandara
Gareth Roberts
Rhys Clyburn
Paul Carter

Warwickshire

Nicholas Talbot

Wessex

Thomas Daubeny ^{Joint ICM}

West of Scotland

Jacqueline McCarthy
Philip McCall

APPOINTMENT OF MEMBERS, ASSOCIATE MEMBERS AND ASSOCIATE FELLOWS

Associate Fellows

Dr Ummara Farooq
Dr Sofia Kalogeropoulou
Dr Dimitar Georgiev Terziiski
Dr Jan Hanot

Member

Dr Tom Joseph Hannan

Associate Members

Dr Amir Ishak Roshdy Mekael
Dr Valentina Camarda
Dr Abdelrahman Ali Mohamed Abdelhadi Eleshmawi
Dr Divya Joseph
Dr Laknath Prasantha Rajasiri
Dr Ivan Pavlu
Dr Amy Farrow
Dr Shaminder Kaur Olney
Dr Mohamed Yousef Saad
Abusheashea
Dr Hani Dourado Al-Khatib
Dr Naomi Mooya Shamambo
Dr Rudy Cathapermal
Dr Tushar Subhash Patil
Dr Rakesh Sethi
Dr Craig Kirk
Dr Nayer Nabil Mikhail Guirguis
Dr Rhiannon Harling
Dr Nour Mohamed Ahmed Youssef ElShafei
Dr Janis Berkis-Bergs
Dr Jaseem Baliyambra
Dr Tarek Ibrahim Elsayed Hassan
Dr Ahmed Mostafa Hassan Eldesoky
Dr Ayman Mohamed Abdelaziz Ibrahim Hassan
Dr Sonam Bi
Dr Khaled Ahmed Ibrahim Mahmoud Sharaf
Dr Ahmed Yehia Mahmoud Mohamed Mahfouz
Dr Natashia Amod Yigit
Dr Shakti Askorum
Dr Yashraj Gupta
Dr Alveena Bilal
Dr Junaid Ahmed Desai
Dr William Pemberton
Dr Aileen Ling Wan Tan
Dr Lokeswaraiah Nagaraju Morubagal

Dr Robin Gregor MacGillivray
Dr Tyng Yan Ng
Dr Amr Essameldin Hussein Ezzat Shalaby
Dr Ahmed Mohamed Abdelrahman Salem
Dr Emmanouil Liolios
Dr Neha Baduni
Dr Neethu Raj
Dr Marta Montero Baladia
Dr Israa Elsayed Mohamed Elfouli
Dr Hanneke Heynen
Dr Dominika Danuta Raciborska
Dr Rachel Elizabeth Friman
Dr Menikhitihami Mudiyansele Erandi Darshika Dissanayake
Dr Amy Chimei Frances Chan-Dominy
Dr Wesam Fawzy Abdelfattah Mohamed Alyeddin
Dr Sunita Gurung
Dr Mohamed Yehya Mohamed Mahmoud
Dr Umme Sumayyah Nauman
Dr Ammar Ali Shah
Dr Nesreen Adel Nasreldeen Ahmed Shaban
Dr Achyut Sharma
Dr Mahaboob Subhani Shaik
Dr Balaji Badrinarayan Putti Ramamurthy
Dr Ola Seifeldin Salih Mohammed
Dr Nilay Chatterjee
Dr Paige Mitson
Dr Melissa Joy Hartley
Dr Maissara Katran Al-Rikabi
Dr Christopher Tong Mun Lewis
Dr Ruth Clara Warne
Dr Claire Patricia O'Doherty
Dr Emma Louise Lang
Dr Emma Jane Carter
Dr Alfred Hill
Dr Gautam Vinubhai Prajapati
Dr Amit Sharma
Dr Thomas Kong
Dr Dasha Faith Tjanara Newington

Affiliates

Mrs Kelly Illingworth
Ms Vala Barzinji
Dr Jodie Hughes

APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

The College congratulates the following fellows on their consultant appointments:

Dr Shelley Barnes, North Bristol Trust
Dr Nicholas Brazel, Nottingham University Hospitals NHS Trust
Dr Neil Hall, South Tyneside and Sunderland NHS Foundation Trust
Dr Amr Hassan, Nottingham University Hospitals NHS Trust
Dr Omar Jundi, Bradford Royal Infirmary
Dr Shyam Kumar Laxman, East Kent Hospitals NHS Foundation Trust
Dr Caroline Martin, Ulster Hospital, Belfast
Dr Lohita Rilesh Nanda, Kettering General Hospital
Dr Gareth Roberts, Princess of Wales Hospital. Cwm Taf Morgannwg University Health Board
Dr Matt Smith, East Lancashire Hospitals NHS Trust
Dr Will Tomlinson, Sheffield Teaching Hospitals

DEATHS

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

Dr Maurice McConnell Burrows, Birkenhead
Dr Douglas Edward Falconer, Newton of Argyll
Dr Trevor Anthony Thomas, Bristol
Dr Bertram Winston Sebastianpillai, Australia

To submit an obituary that will be displayed on our website (rcoa.ac.uk/obituaries), please email your text (500 words) to archives@rcoa.ac.uk

Gasping for a Breath

Before I got on the ventilator
I never knew how important it was
To breathe.
Before they put me in coma
I never paid attention
To being conscious.
Before I lost my taste and smell
I ignored the fragrance of nature and taste of water.
Before all my blood was run through machines
I was indifferent to the life within.
Before I got a tube in my throat
I never admired my voice, my speech.
Before I had my eyes closed
I never adored the shades of sunset.
Before I said goodbye to my family
I never said 'I love you' enough.
And now it's time to go
Far, far away.
If only I could get a breath, there is so much left to say.

Dr Lubaina Bahar

ICM Fellow, Royal Brompton Hospital, London

Raising the standards

new edition of the quality improvement compendium now available

at: bit.ly/RCoAQIComp





VACANCY: DIRECTOR

The UK Perioperative Medicine Clinical Trials Network (POMCTN) was established in 2015 as a national network to deliver world-class multi-centre clinical trials in anaesthesia and perioperative medicine.

The POMCTN is now recruiting a new director as the current director term nears its end. This role will include overseeing the successful delivery of all network-led clinical trials, working closely with chief investigators to ensure that trials are well supported, as well as leading and developing the strategy of the Network.

The POMCTN is a collaborative national network of active local and principal investigators who are running clinical trials recruiting NHS patients. The Director will have appropriate skills and qualifications including direct experience in leading large clinical trials, strong leadership and interpersonal skills, communication and presentation skills to effectively chair meetings and events.

This is a three-year fixed term appointment, subject to annual review and we are currently seeking funding renewal for one PA backfill for the post. The post can be renewed for one additional term to a maximum of six years.

Further details on the role including a full job description and person specification are available on the POMCTN website at: pomctn.org.uk/article.php?newsid=158. If you would like to discuss the role with current Director Professor Rupert Pearse please email: pomctn@niaa.org.uk.

Closing date for applications:
Monday 22 February 2021.

Interviews will be held in March 2021
[date TBC].

Fitter Better Sooner

Endorsed by



The College has developed a toolkit that offers patients the information they need to prepare for surgery, including the important steps they can take to improve health and speed up recovery after an operation.

The Fitter Better Sooner toolkit consists of:

- one main leaflet on preparing for surgery
- six specific leaflets on preparing for some of the most common surgical procedures
- an animation which can be shown on tablets, smart phones, laptops and TVs.



You can view the toolkit here: rcoa.ac.uk/fitterbettersooner

We have also created printable posters, flyers and stickers to help you signpost patients to the toolkit. The animation can be shown on TVs in waiting areas. You can find all these additional resources and instructions on how to download the animation in MP4 format (or request a version in PowerPoint) on our website here: rcoa.ac.uk/patientinfo/healthcare-professionals

Please share this toolkit with colleagues in both primary and secondary care settings.



COVID-19 RESOURCES
Stay up-to-date with all our latest clinical resources and guidance for anaesthetists & intensivists. Find out more at: icmanaesthesiacovid-19.org

Trainee Conference 2021
7-9 July 2021, St James' Park, Newcastle Football Club, Newcastle

Join us at the national conference for anaesthetists in training, first-year consultants and medical students.

Save the date!
anaesthetists.org/TraineeConference

Association of Anaesthetists

REVISED DATES
7-9 JULY 2021

Friends, Don't Let Friends Palpate Blindly.
(LANDMARKS CAN BE TRICKY.)

Accuro's ultrasound image guidance system automatically identifies spinal midline, trajectory, and depth during neuraxial anaesthesia and is superior to 'blind' palpation irrespective of provider experience, as demonstrated in controlled trials.

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- 48% Reduction in needle redirects.
- 57% Reduction in needle insertion time.
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Performance claims from D. Ghisi et al. (2019) and Singla et al. (2019)
736-00042 Rev A

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September 11th - 13th, 2020
Abstract submission now open

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EBPOM Ireland, Dingle 2020

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November 10th & 11th, 2020
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Mersey School of Anaesthesia

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

COVID-19/MSA NOTICE

At the time of this Artwork Design (August 2020);
We are unable to predict the certainty of Courses going ahead.
Proposed Dates will be listed on the Website, however, given the circumstances,
please note they are always subject to change.

All updated Dates and Notices can be found on our Website or Social Media Channels
www.msoa.org.uk

E-BOOKER COURSE for the Final Written Examination March 2021

A 5/6 day Intensive Course
February 2021
Limited to 90 Places

Including;
12-Question CRQ E-Papers & Review
Presentations on Key Points on Various FRCA Sub-Specialties
SBA E-Papers

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A Peer Learning opportunity
starting 6 months before the Exam

Providing opportunities to Exercise & Practice New CRQ
Question Formats & Techniques
via our newly developed Software

This will involve;
Drafting Questions/Answer Guidance from Hot Topic Articles
Anonymously Completing CRQs under Timed Conditions
Anonymously Marking CRQ Answers for Fellow Members
Acquisition of useful Answer Guidances from Other Members

Candidates are urged to join before April 2021 for the
October 2021 Examination to gain Maximum Benefit

PRIMARY & FINAL
SBA Crammer E-CLUBS

A Peer Learning opportunity
starting 2 months before the Exam

The Aims:

- To ensure Reading & Understanding of select Topics from the Syllabus
- To Identify Gaps in Knowledge & Learning
- To Consolidate Learning by completing Weekly SBA Tests followed up with Review & Guidance on Answers from Fellow Members

This Club will facilitate you into spending
at least 10 Hours/week in focused
Private Study/Revision for your Exam

PRIMARY OSCE/VIVA & FINAL VIVA Revision E-CLUBS

Including Video Viva Clubs for Viva Practice

Currently (August 2020) in Planning

PLEASE NOTE;

Trainees planning on attending MSA Courses must appreciate before they attend, that the MSA Courses are designed for Exam Preparation only, and include;

- Exposure to Exam Style Questions
- Opportunities to Practice
- Learn & Fine Tune Exam Techniques

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.

ONLINE WINTER SYMPOSIUM:


3–4 December 2020

We will be live streaming this event from our Lecture Theatre at Churchill House, as well as bringing in national and international experts to join the discussion from their locations both in the UK and across the world.

Programme includes:

- Christmas lecture
- panel debates
- innovations
- artificial intelligence
- quick fire abstract talks.

Full programme available online at rcoa.ac.uk/events



Anaesthetic updates

MEET | LEARN | DISCUSS



Virtual events

19 November 2020

Clinical Content Lead

Dr Nagendra Prasad, Consultant Anaesthetist

Topics include:

- Perioperative analgesia
- Airway management
- Obstetrics

Future dates

Southampton

29 January 2021

London

24–26 February 2021

Bristol

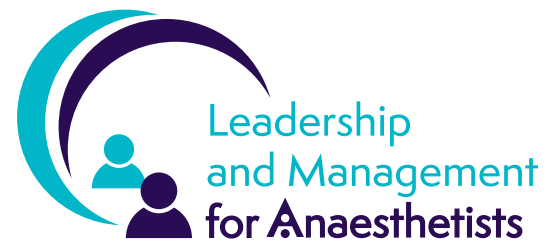
4 March 2021

Due to the ongoing COVID-19 situation, we are monitoring the guidance on events and if it is not possible to run these events face to face, then we will move these to virtual platforms.

For further information and to book please visit: rcoa.ac.uk/events

**10%
DISCOUNT**

Off your second course if booked within six months of the first or if two booked at the same time.



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Run by practicing NHS clinical directors and experienced management facilitators – start with our signature two-day introduction course and follow up with one of our suite of management courses.

Working Well in Teams and Making an Impact

18 November 2020
RCoA, London

Introduction to leadership and management: The essentials

16–17 March 2021
Glasgow

Personal Effectiveness

26 March 2021
RCoA, London



REVISION COURSES

Primary FRCA Online Revision Course

Start date 1 December 2020
Content will be available until the exam in February

Final FRCA Online Revision Course

Start date 14 December 2020
Content will be available until the exam in March

These courses include:

- video lectures
- powerpoint presentations
- mock exams
- chat room for discussion between trainees
- the opportunity to send in questions to lecturers and receive feedback.

Book online now at: rcoa.ac.uk



UPCOMING WEBINARS

RCoA and RA-UK joint webinar:
Blocks for the many
10 November 2020, 6.30pm–8.00pm (GMT)

RCoA and BJA joint webinar:
How BJA Editors decide which papers to publish
24 November 2020, 6.30pm–8.00pm (GMT)

New webinars are released regularly. Please visit our website for dates, topics and speaker information.

rcoa.ac.uk/webinars

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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