SEAUK

The Society for Education in Anaesthesia UK

BRISTOL, 20TH APRIL 2026

Annual Scientific Meeting 2026

ASM Programme Highlights include:

- **The Expanding Role of the Anaesthetist**
- PHEM | The Developing World | Perioperative Phyician | Sustainability
- **Women in Anaesthesia Panel**
- **Innovation in Education**

  Augmented Reality | Simulation in Anaesthesia | The **Utility of Chat GPT**

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The Society for Education in Anaesthesia UK

Registered Charity No. 1091996

26th ANNUAL SCIENTIFIC MEETING Programme
Monday 20th April 2026

8:30	**Registration**	
9:00	**Introduction and Welcome**	Dr Umair Ansari *President SEA UK* *Dr Amit Ranjan Local Organiser*
	Session 1	The Expanding Role of the Anaesthetist
09:15	**PHEM**	*Dr Tom Renninson, consultant Anaesthetist, Gloucestershire Hospitals NHS Foundation Trust, Prehospital Critical Care Consultant EMRTS Cymru (Wales Air Ambulance(*
09:40	**Anaesthesia in The Developing World**	Dr Chris Walker, Consultant Cardiac Anaesthetist & Intensivist, Cleveland Clinic Hospital, London
10:05	**Frailty & the Perioperative Physician**	Dr Frances Rickard, Consultant in Geriatric Medicine, North Bristol Trust, Bristol
10:30	**Sustainability in Anaesthesia**	Dr John Hickman, Consultant Anaesthetist & Sustainability Lead, University Hospitals Bristol and Weston, Bristol
10:55	**Poster Judging**	Group 1
10:55	**Refreshments**	
11:15	**Session 2 Women in Anaesthesia**	Dr Fiona Donald – Chair, Retired Consultant Anaesthetist, Former RCoA President
	Equity of Training Opportunities in Regional Anaesthesia	Dr Jenny Ferry, Consultant Anaesthetist, EDI Lead for RA-UK
	Women's Health & Training	*Dr Lucinda Whitton, Anaesthetic Resident, Severn Deanery, AoA Resident Committee Member*
	Breaking Down Barriers in Trauma Anaesthesia	Dr Nirosha DeZoysa, Consultant Anaesthetist & Major Trauma Centre Clinical Lead, North Bristol Trust, Bristol
	From Airway to Echocardiography; The Evolving Identity of the Anaesthetist	Dr Jess Webster, Consultant Cardiac Anaesthetist & Cardiac Intensivist, Bristol Heart institute, Bristol
12:15	**Poster Judging**	Group 2
12:15	**AGM**	SEA UK Members & Council
12:15	**Lunch**	
	Session 3 – Innovation in Education	
13:15	**Simulation**	Dr Junaid Fakuta, Consultant Anaesthetist (Special Interest Medical Education and Simulation), University Hospitals Bristol
13:40	**Augmented Reality in Regional Anaesthesia**	Dr Arul James, Consultant & Chronic Pain Management, George Elliot Hospital, Nuneaton
14:05	**Debate: Does ChatGPT have a Place in Anaesthetic Training & Education?**	Dr Ed Miles vs Dr Matt Aldridge Consultant Anaesthetists, North Bristol Trust, Bristol
14:40	**Refreshments**	
14:40	**Poster Judging**	Group 3
	Key Note/Plenary Session	
15:00	**A Career in Education**	Dr Mike O'Connor, Retired Consultant Anaesthetist
15:25	**Training in Research**	Dr Ned Gilbert-Kawai, Consultant Anaesthetist & Intensivist, Royal Liverpool Hospital, Liverpool
15:50	**Free Paper Session**	*Oral Presentations*
16:25	**Top Papers**	Dr Swati Gupta, Anaesthetic Trainee, Severn Deanery Dr Jon Barnes, Consultant Cardiac Anaesthesia, Bristol Heart institute, Bristol
16:40	**Prizes & Closing Summary**	

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26th ANNUAL SCIENTIFIC MEETING Programme

Monday 20th April 2026

Venue: Bristol Hotel

Welcome from the President – Dr Umair Ansari

It is my great pleasure to welcome you to this year's meeting of the Society for Education in Anaesthesia, hosted in the historic and vibrant city of Bristol. On behalf of the organising committee and our society, I extend a sincere welcome to all delegates, speakers, residents, and collaborators who have joined us for what promises to be an inspiring meeting.

Bristol is a city whose character is shaped by centuries of innovation, enterprise, and learning. Education and scholarship have long been central to the city's development, culminating in the establishment of a medical school whose roots extend back to the eighteenth and nineteenth centuries, reflecting Bristol's enduring commitment to advancing healthcare and professional training.

This year we have received an exceptional number of abstract submissions, representing a breadth of engagement and hard work that speaks to the strength and diversity of our community. The reviewers faced the unenviable task of selecting from an outstanding pool of high-quality work, demonstrating both academic rigour and practical relevance to modern clinical practice. Please do spend some time during the conference reviewing the exceptional poster presentations from across the Country.

The year's programme showcases excellence across multiple domains. We explore the expanding role of the anaesthetist—not only as peri-operative physician, but as educator, innovator, leader, and advocate for patient safety across healthcare systems. Dedicated sessions highlighting women in anaesthesia celebrate leadership, mentorship, and the continued advancement of equity within our specialty. Meanwhile, presentations focused on innovation in anaesthesia demonstrate how technology, research, and educational creativity continue to redefine how we deliver care, train future clinicians, and improve outcomes for patients.

I encourage you to engage fully with the programme—attend sessions beyond your usual interests, challenge established thinking, support emerging researchers, and take time to reconnect with colleagues old and new. Conferences such as this remind us that education is not merely the transfer of knowledge, but the cultivation of professional identity, community, and purpose.

Finally, I would like to express my sincere gratitude to the organising committee, council members, reviewers, and sponsors whose dedication has made this meeting possible. Most importantly, thank you to each of you for contributing your expertise, enthusiasm, and commitment to advancing education in anaesthesia.

I wish you a stimulating, enjoyable, and memorable conference in Bristol and I look forward to unveiling the details of our ASM for 2027.

Welcome Message from the Local Organisers

We are delighted to welcome you to the Society for Education in Anaesthesia UK (SEA-UK) Annual Scientific Meeting, taking place on 20 April 2026 at The Bristol Hotel, Harbourside, Bristol.

SEA-UK ASM 2026 offers a full day of insightful discussions, expert-led sessions, and opportunities for collaboration. The programme highlights the expanding role of the anaesthetist in modern healthcare, alongside key themes of innovation, education, diversity, and sustainability.

A highlight of the morning is our dedicated Women in Anaesthesia session,chaired by former RCoA President Dr Fiona Donald, which will explore equity in training, women's health, leadership, and the changing identity of the anaesthetist. This panel celebrates the individuals shaping the future of our profession and underscores the importance of representation, mentorship, and opportunity within anaesthesia.

In the afternoon, the focus shifts to Innovation in Education. From simulation and augmented reality to a lively debate on the role of AI tools such as ChatGPT in training, we will examine how emerging technologies are transforming how we teach and learn. These sessions are designed to provide practical insights into integrating innovation responsibly into clinical education.

The programme also features a keynote plenary session from Dr Mike O'Connor on Careers in Education, as well as perspectives on training in research and opportunities to engage with papers and abstracts from colleagues across the UK.

Join us for a day of learning, inspiration, and collaboration in the vibrant city of Bristol. Whether you are a trainee, educator, or consultant, we hope this conference will inspire new ideas, foster collaboration, and support your development as an anaesthetist and educator.

We look forward to welcoming you.

Sioban Perry

Subhabrata Hal

Claire Abeyesekara

Jon Barnes

Emma Low

Meet the Speakers
SEA UK ASM 2026 Bristol Hotel

Dr Tom Renninson Consultant Anaesthetics, Gloucestershire Royal Hospitals NHSFT Consultant Pre-Hospital Critical Care, Emergency Medical Retrieval and Transfer Service Cymru (Wales Air Ambulance)

Tom trained in the Severn region and now is a consultant anaesthetist in Gloucester specialising in non-elective and remote site anaesthesia. He divides his work between in hospital anaesthetics and pre-hospital care in Wales.

Dr **Chris Walker** is lead for cardiothoracic anaesthesia at Cleveland Clinic London.

Previously, Chris was chairman of Anaesthesia & Critical Care at Harefield Hospital, part of the Royal Brompton & Harefield Hospitals in London. During his time there, he led the acute pain service and developed a particular interest in fast-track critical care, pain management, and
recovery after cardiac and thoracic surgery. He also led the fellowship programme for over a decade.

Dr Walker has a background in military service, having seen active duty in field hospitals with the British Army as a Reservist. This experience has informed his interest in humanitarian work, including involvement with charities helping to establish cardiac surgery programmes in some
of the poorest emerging nations and support the training of local teams."

Dr Frances Rickard is a Consultant Geriatrician specialising in Major Trauma and Perioperative Care. After graduating from Warwick Medical School, she completed her post-graduate training in the Southwest, before beginning her consultant career at Southmead Hospital in Bristol in early 2023.

Her inpatient work involves caring for older adults admitted with major trauma, as well those with other surgical pathologies across GI, vascular, urology, and plastic surgery. Her special interest within trauma is management of patients with cSDH; she has been part of working groups within the UK and Europe centring on improving cSDH care, and has developed regional services to promote equitable access to MDT shared decision making and MMA embolisation.

She is currently a committee member for the British Geriatric Society Perioperative Medicine Special Interest Group, as well as Secretary for the European Geriatric Medicine Group.

Dr John Hickman is a consultant anaesthetist at University Hospitals Bristol and Weston NHS Foundation Trust. He has been actively involved in sustainability in healthcare for over 10 years, leading projects in the perioperative setting which have subsequently been replicated at national and international level. He is co-founder of the Severn Environmental Anaesthesia and Sustainability Network (S.E.A.S.N) and is now a member of the Bristol Sustainable Healthcare Collaboration.

Dr Fiona Donald MB ChB FRCA OBE. Fiona qualified from Bristol University Medical School in 1985 and started her training in anaesthesia in 1987. Over the course of the next 10 years she worked in the Severn region, Oxford and Geneva and was appointed to a consultant post at Southmead Hospital in Bristol in 1997. Her main areas of clinical and research interest were obstetric anaesthesia and teamwork training.

Fiona has held a number of education-related posts over the course of her career. These include being college tutor at Southmead Hospital, educational supervisor to anaesthetic resident and Foundation doctors, Chair and education lead for the Board of the Bristol School of Anaesthesia, an examiner for the Fellowship exams (FRCA) of the Royal College of Anaesthetists, and Chair of the Final FRCA.
Fiona is the immediate past President of the Royal College of Anaesthetists and retired from clinical work in 2024. She was awarded an OBE for services to Anaesthesia, Intensive Care and Pain Medicine in the King's New Year Honours.

Dr Jenny Ferry is a Consultant Anaesthetist working in South Wales, UK. Her clinical interests include regional anaesthesia (RA) and acute pain, serving as clinical lead for acute pain at her Health Board.

In 2023, she was elected to the Board of Regional Anaesthesia UK (RA-UK), where she has led the organisation's work on Equity, Diversity and Inclusivity. Her key achievements include driving gender balance across Approved Courses and RA-UK events, embedding EDI principles into RA-UK events, and establishing a support network to help clinicians with caring responsibilities participate as course faculty.
Jenny is a regular speaker at national conferences, including those hosted by the Association of Anaesthetists, RA-UK, the British Association for Day Surgery and the British Society of Orthopaedic Anaesthetists, where she presents on regional anaesthesia, acute pain, and approaches to medical education. She is part of the team behind FUSIC blocks, a workstream of the Intensive Care Society, aiming to train clinicians to provide regional anaesthesia to intensive care patients across the UK.

She authored the international Research Priority Setting Project in regional anaesthesia—a global collaboration to define future research priorities in the field. She has also co-authored multiple publications on topics including artificial intelligence in regional anaesthesia and minimum standards for ultrasound imaging in RA.

Outside of work, she is a mother to two amazing children. She is a slow runner, and an average boulderer. She enjoys knitting – proving it's not just block needles that she's handy with!

Dr Lucinda Whitton is an anaesthetic doctor currently working as a Simulation Fellow at the Royal United Hospitals Bath, with a strong interest in medical education, resident experience, and workforce wellbeing. She is the Less Than Full-Time (LTFT) Representative on the Association of Anaesthetists Resident Doctors Committee, where she advocates for equitable and sustainable training.

Lucy has a particular interest in how training structures intersect with residents' health, including fertility, pregnancy loss and pregnancy and is the Chief Investigator of a national mixed-methods study exploring these experiences among anaesthetic residents. Her work aims to inform more inclusive training pathways and support cultural change within the profession. Alongside this, she is actively involved in delivering innovative education programmes and simulation training, with a focus on creating supportive learning environments and improving multidisciplinary teamwork.

Dr Nirosha DeZoysa is a Consultant Anaesthetist and the Clinical Lead for Major Trauma at North Bristol NHS Trust. Graduating from Kings College London, she moved to Bristol to complete specialist training in Anaesthesia in the Severn region. During this time, she completed advanced Trauma training in Bristol and Sydney as well as a Masters in Trauma Sciences from QMUL. Her clinical interests include Trauma, Vascular and Obstetric Anaesthesia with a particular focus on the challenges posed in high-acuity settings for decision making, team dynamics, learning and safety. In addition to her clinical work, Nirosha is dedicated to championing equity and inclusion within healthcare for staff and patients.

Dr Jess Webster Consultant Cardiac Anaesthetist & Cardiac Intensivist, Bristol Heart institute, Bristol

Dr Junaid Fakuta is a Consultant Anaesthetist at University Hospitals Bristol and Weston and Founding Director of MedRevision Ltd. A passionate educator and innovator he has won 2 national awards for his work in the Technology Enhanced Learning sphere as well as led numerous research projects in medical education at the University of Bristol. He has set up the TRU-VR (TRaining Utilising Virtual Reality) programme which incorporates Virtual Reality Simulation for the training of medical and nursing staff for critical incidents. Building on work with NHS Innovation he has recently been accepted onto the NHS Clinical Entrepreneur Programme to bring VR simulation training to a national audience.

Dr Arul James is a UK-based Consultant in Anaesthetics and Chronic Pain Medicine with over 10 years of clinical experience across the NHS and private sector. He is the founder and creator of ARiRA – Augmented Reality in Regional Anaesthesia https://www.arira.co.uk<https://www.arira.co.uk/>, an innovative online education platform delivering ultrasound-guided regional anaesthesia training using 3D anatomy, cadaver anatomy, augmented reality, sono-anatomy and interactive virtual probe control. Arul is also the creator of FRCA.Ai https://www.frca.ai<https://www.frca.ai/>, an AI-powered learning platform designed to support anaesthetic trainees preparing for the Primary and Final FRCA examinations, aligned with the RCoA curriculum, podcast style Q&A which you can pause to answer rather than passively listen and an interactive - Ai, video-based examiner for unlimited mini-mock SOE practice.

Since 2021, he has served as the Clinical Lead in Chronic Pain Medicine for George Eliot Hospital NHS Trust, delivering specialist biopsychosocial pain management alongside advanced interventional procedures including ultrasound- and X-ray-guided injections, radiofrequency denervation, infusions, and cryoablations more recently. He has performed over 1,000 pain interventions in the past two years alone and leads patient-centred, multidisciplinary care focused on long-term functional improvement.

Dr James is a Fellow of the Royal College of Anaesthetists (FRCA) and the Faculty of Pain Medicine (FFPMRCA), and is the author of Empowering Pain Management https://amzn.eu/d/0yiDMOJ, a practical guide for patients living with chronic pain. Through ARiRA and FRCA.Ai, his work integrates clinical expertise, medical education, and digital innovation to support both patient care and anaesthetic training at scale.

Dr Ed Miles is a Fellow of the Royal College of Anaesthetists and was appointed a Consultant in Anaesthetics at North Bristol NHS Trust in 2021. He has a special interest in Obstetric Anaesthesia and works regular sessions in Central Delivery Suite and the Elective Obstetric Theatres on our Southmead site. He also regularly delivers general and regional anaesthesia across our surgical specialities in the main Brunel Theatres complex, and sees patients prior to their planned surgery at our Pre-operative Assessment Clinic.

Outside of his clinical duties, Edward has an interest in Postgraduate Medical Education and the use of Simulation in both individual and team-based training. Edward has led several large-scale simulations across our organisation and is passionate about using the tool to improve the care we deliver to our patients and the professional development we provide to our colleagues. He is an accredited Educational Supervisor with responsibility for supporting postgraduate doctors in training programmes delivered across North Bristol NHS Trust.

Dr Matt Aldridge is a Consultant Anaesthetist at North Bristol NHS Trust with interests in medical education and artificial intelligence (AI). He is an advocate for the ethical development of medical AI, and the use of human factors science to build AI systems that enhance the human interactions at the centre of healthcare. He views AI both as a crucial societal shift to understand, and as an exciting new resource for medical educators to engage and connect with learners.

Dr Mike O'Connor graduated in Medicine from Bristol and trained in Anaesthetics in Bristol, Oxford and Adelaide before settling as a Consultant in Swindon. Mike was College Tutor in Swindon and subsequently Director of Medical Education. Nationally he was an examiner in the Primary and Final FRCA examinations and helped set up the Faculty of Pain Medicine exam. In 2008 he took up the role of Associate Dean in Severn Deanery and set up the Professional Support Unit. He gained his Postgraduate Certificate in Medical Education from the University of Wales in 2003 and completed his coaching qualification with the Institute of Leadership and Management in 2017; he is accredited as a trainer on ILM coaching courses.

Internationally Mike was heavily involved in the International Essential Pain Medicine (EPM) course and over the last few years has taught in Russia, Tanzania, the Palestinian Territories, Belarus, Serbia, South Africa and Zambia. He was awarded a Commendation by the Faculty of Pain Medicine for his work in education both in the UK and overseas.

Mike has recently been buying books on time-management but hasn't yet had an opportunity to look at them.

Dr Ned Gilbert-Kawai is an Anaesthetist and Intensivist at The Royal Liverpool Hospital. Having trained in Birmingham, he moved to London (via Southampton) to pursue a career as an academic clinician and completed his PhD at UCL. Ever enthusiastic to try new things (much to the dismay of those around him), he eventually finished his anaesthetic and ICM training as a 14th-year SpR, and has since continued his career attempting to balance ICM, anaesthesia, and academia.

Dr Swati Gupta is a resident anaesthesia doctor in the southwest, chair-elect of the Severn Trainee Anaesthesia Research Network (STAR) and co-lead for the 5th national Research and Audit Federation of Anaesthetists in Training (RAFT) project SECURE. She has a specialist interest in airway management, trauma management, and safety-focused transformative simulation. She has lived in four different countries and in her spare time she enjoys painting landscapes and running after her two little ones.

Dr Jon Barnes is a consultant in cardiac anaesthesia and critical care at the Bristol Heart institute and an honorary senior lecturer at the University of Bristol. His main research interest is in collaborative clinical trials and perioperative interventions to improve patient outcomes. He sits on the ACTACC national executive and research committees and has an active education practice, as course director for a number of programmes and local training module lead.

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Oral Presentations

1. Evaluating a Team Wellbeing-Focused Hot Debriefing Tool (PITSTOP) Within The Anaesthetics Department, North Bristol NHS Trust

Dr Olivia Donnelly[1], Consultant Clinical Psychologist,, Dr Emma Lishman[1], Consultant Psychologist, Dr Charlotte Phillips[2], Consultant Psychologist, Dr Amy Dodd [1,] Consultant Anaesthetist, Dr Kevin R.H. Teoh[2,] Reader in Work and Organizational Psychology, Dr Fiona Frost[2,] Research Assistant, [1]Birkbeck Business School, Birkbeck University of London, London [2]Southmead Hospital, North Bristol NHS Trust, Bristol

Introduction: NAP7 highlighted that anaesthetists are frequently exposed to adverse patient events [1]. Without adequate support, the psychological impact of such events on the clinicians involved, can evolve into longer-term psychological morbidity [2]. While 'hot debriefing' is recommended, institutional barriers can prevent its use and the focus is often on learning rather than wellbeing. We evaluated the effectiveness of 'PITSTOP' [3], a brief, peer-led training intervention designed to upskill anaesthetists in facilitating wellbeing-focused hot debriefs.

Method: We conducted a prospective, longitudinal, mixed-methods study using a pre-test/post-test design with a six-month follow-up. Anaesthetists (n=46) attended a 90-minute experiential training session on the PITSTOP model. Participants completed surveys assessing confidence, knowledge, and attitudes at three time points: pre-training, immediately post-training, and at six-month follow-up. Primary outcomes were self-reported confidence to support peers and knowledge of the intervention. Qualitative data regarding implementation barriers were analysed thematically.

Results: Baseline exposure to trauma was high, with 89% of participants reporting an adverse event in the previous year. Training resulted in significant immediate improvements across all domains of confidence and knowledge ($p < 0.001$). At six-month follow-up (n=19; 42% retention), general confidence to support colleagues remained sustained and significantly higher than baseline. However, specific technical knowledge of the debrief steps and institutional signposting pathways showed significant decay. Following training, 21% of respondents had facilitated a PITSTOP in clinical practice. Qualitative analysis identified 'operational pressure' and 'role ambiguity' as key barriers preventing implementation.

Table 1. *Pre and post training evaluation scores*

Item	Question	N	Pre	Post	t statistics	Cohen's d
1	Having an understanding of psychological trauma is important to my role	41	5.59	5.76	$t(40) = -1.86$	0.29
2	I am aware of common reactions to adverse events	41	4.61	5.56	$t(40) = -8.23^{***}$	1.29
3	I feel confident to support a colleague after an adverse event	41	4.00	5.27	$t(40) = -10.94^{***}$	1.71
4	I am aware of helpful steps I can take to support myself after an adverse event	41	4.41	5.41	$t(40) = -7.65^{***}$	1.19
5	I am aware of when someone might need to access psychological support	41	4.29	5.34	$t(40) = -9.08^{***}$	1.42
6	My team come together when faced with difficulties	41	4.66	5.07	$t(40) = -3.43^{**}$	0.54
7	I know how to support my team when an adverse event occurs at work	41	4.12	5.24	$t(40) = -8.24^{***}$	1.29
8	I understand what a PITSTOP is	41	3.61	5.71	$t(40) = -11.39^{***}$	1.78
9	I would feel confident in running/ facilitating a PITSTOP	41	2.78	5.27	$t(40) = -14.50^{***}$	2.26
10	I am aware of the support options available through the Staff Trauma Support Pathway at [organisation]	41	3.90	5.51	$t(40) = -9.86^{***}$	1.54
11	I am aware of different types of wellbeing support available within [organisation]	41	4.05	5.44	$t(40) = -9.99^{***}$	1.56

Note. $^{*}p < .05$, $^{**}p < .01$, $^{***}p < .001$

Discussion: The PITSTOP training is effective in producing sustained improvements in anaesthetists' confidence to support peers. However, a 'knowing-doing' gap persists, where high confidence does not translate into routine clinical implementation due to systemic barriers. To bridge this gap and counteract skill decay, the use of visual cognitive aids and provide explicit leadership authorisation to empower anaesthetists to pause for debriefing should be encouraged.

References:

1. Kursumovic, E.; Davies, M.; Martin, S.; Wain, E.; Lucas, N. Managing the Aftermath and Learning from Perioperative Cardiac Arres. In *NAP7 Report*; Soar, J., Cook, T., Eds.; Royal College of Anaesthetists, 2023; pp. 184–195.
2. Gazoni, F.M.; Amato, P.E.; Malik, Z.M.; Durieux, M.E. The Impact of Perioperative Catastrophes on Anesthesiologists: Results of a National Survey. *Anesth. Analg.* **2012**, *114*, 596–603, doi:10.1213/ANE.0b013e318227524e.
3. Donnelly, O.M., Rettie, H.C., Page, A.C.E., & Teoh, K.R.H. (2025). The effectiveness of the peer-led PITSTOP (hot debrief) training for healthcare professionals. Occupational Psychology Outlook. https://doi.org/10.53841/bpsopo.2025.4.2.38
4.

Oral Presentations

2. A National Lecture Series and Online Learning Platform to Standardise Postgraduate Anaesthesia Training: A Quality Improvement Initiative

Riona Tully[1], Nick DiMascio[1], Darragh O'Reilly[1] [1] College of Anaesthesiologists of Ireland

Background: Postgraduate anaesthesia trainees through multiple hospitals to ensure broad subspecialty exposure. However, centralisation of complex surgical services and variability in departmental teaching mean that clinical exposure and formal teaching do not always align with examination blueprints. Consequently, trainees may experience perceived inequity in curriculum coverage and exam readiness. A 2022 national anaesthesia training survey demonstrated strong support for a structured national teaching programme, with 88.7% of trainees and 92.3% of clinical tutors endorsing the value of a national lecture series.

Aims: This quality improvement initiative aimed to:

1. Deliver a standardised, curriculum-mapped national teaching programme aligned with examination blueprints
2. Mitigate temporal inequity in educational exposure arising from rotational training and service centralisation
3. Ensure equitable access to high-quality education for all trainee anaesthetists
4. Support sustainable, technology-enhanced learning.

Methods: A national pilot programme was launched in 2023, delivering three consultant-led lectures per month tailored to Specialty Anaesthesia Trainee cohorts. Lectures were livestreamed and recorded on a dedicated online learning platform to facilitate asynchronous access. Mid-year evaluation using trainee and consultant surveys assessed engagement, barriers to attendance, and perceived educational value. Findings informed iterative refinement of programme delivery.

Results: Live attendance was limited by clinical service pressures. Trainees reported difficulty leaving clinical duties due to short staffing, while tutors highlighted competing service demands and concerns regarding displacement of clinical learning by didactic teaching. Despite these challenges, >75% trainees reported that lecture content was relevant and applicable to their training stage. Perceived benefit for examination preparation was variable, reflecting differences in trainee exam status and exam outcomes at the time. Asynchronous access to recorded lectures was valued in mitigating these barriers.

Conclusion: A national, technology-enhanced lecture series can reduce temporal inequity in postgraduate anaesthesia education by decoupling curriculum coverage from rotation timing. Iterative, feedback-driven adaptation is essential to its success.

Oral Presentations

3. VR-STOrM - Virtual Reality-Based Simulation Training for Obstetric Multidisciplinary Teams: Development, Delivery & Effectiveness Analysis.

Ascough, Caitlin[1]; Meredith, Rachael[1]; Saunders, Katherine[1]; Crowther, Nicola[1]; Fukuta, Junaid[1]
1.University Hospitals Bristol and Weston NHS Foundation Trust

Introduction: The Ockenden Report[1] highlights multidisciplinary team (MDT) simulation as a key strategy for improving maternity safety. However, MDT simulation is resource-intensive and challenging to deliver consistently across multiple specialties. Virtual reality (VR) simulation provides a portable and interactive alternative, with the potential to support MDT training for rotational anaesthetist's induction to new departments.

Methods: We produced a novel multidisciplinary major obstetric haemorrhage VR simulation package filmed from the perspective of anaesthetist, midwife, and obstetrician, with embedded specialty-specific training packages and interactive decision-making elements. A pilot trial was conducted during induction for rotational anaesthetic residents, comparing participants' knowledge and confidence before and after delivery, and collecting qualitative data on the effectiveness of the intervention as a training modality.

Results: Our multidisciplinary VR simulation package has been delivered to 42 anaesthetists to date. Following training, learner confidence increased by a mean of 0.91 points to 4.36/5. 95% of learners felt the training reflected MDT working and gave them better insight into other MDT members' roles. 95% would like further VR training. Qualitative feedback highlighted advantages over in-person simulation, including reduced performance anxiety, improved information uptake from a 'bird's-eye' view, and the value of demonstrating local environment and protocols in a new trust.

Discussion: VR simulation was a novel modality for most participants, with minimal reported barriers. Staff availability is often the main limitation, which we have demonstrated can be mitigated by embedding training within existing induction processes. We suggest it could also be used to further professional development for anaesthetists covering obstetrics who do not have regular obstetric anaesthetic practice, in line with the Guidelines for Provision of Anaesthetic Services[2]. In conclusion, development and delivery of a multidisciplinary VR simulation package is feasible and represents a valuable, reproducible addition to existing simulation curricula across trusts.

References: (1) Ockenden, D. (2022) Ockenden Review: Summary of findings, conclusions and essential actions, GOV.UK. https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions (accessed 14 January 2026).
(2) Royal College of Anaesthetists. Guidelines for the Provision of Anaesthetic Services (GPAS) [Internet]. London: Royal College of Anaesthetists; 2024. Available from: https://www.rcoa.ac.uk/safety-standards-quality/guidance-resources/guidelines-provision-anaesthetic-services (accessed 5 February 2026)

Oral Presentations

4. Bridging the Viva Gap: A Theory-Informed AI Platform to Enhance FRCA Preparation

Dr Hooi Shin Ng, Anaesthetics ST4, Warwickshire School of Anaesthesia, Dr Arul James, Consultant Anaesthetist and Chronic Pain Management, George Eliot Hospital, Nuneaton. Founder and creator of FRCA.Ai & ARIRA.co.uk.

Background: The Fellowship of the Royal College of Anaesthetists (FRCA) examination is a high-stakes milestone in UK anaesthetic training. While artificial intelligence (AI) tools are increasingly used in exam preparation, patterns of use and candidate expectations remain unclear. We explored current preparation strategies to inform development of a deliberate-practice-based AI viva platform.

Methods: A cross-sectional survey of anaesthetic doctors at varying stages of FRCA progression (Pre-Primary, Post-Primary, Final and post-Final) was conducted. The questionnaire included exam preparation duration, consultant and peer viva practice frequency, learning preferences, AI usage, exam stress, confidence, and desired features of online platforms.

Results: Twelve responses were analysed across training grades (CT3–ST5, SAS, locally employed, MTI and consultants). Exam preparation ranged from 1–20 weeks, with anticipated totals of 3–6 months. Most reported consultant or peer viva practice once every two weeks or less. Exam stress was high (4–5/5), while confidence was moderate (3–4/5).

Traditional resources, including textbooks, question banks and courses, predominated. Around half reported weekly or more frequent AI use, mainly for concept explanation, question generation, summarisation and exam strategy. Confidence using AI was moderate to high (median 4/5).
Across grades, prioritised features included knowledge-gap identification, personalised constructive feedback, realistic exam simulation, alignment with FRCA marking patterns and time efficiency.

Educational Innovation: FRCA.AI was developed as an educational platform grounded in deliberate practice and individualised feedback for learning. Using real-time video-based AI, it delivers structured, domain-aligned viva questioning, exam-style simulation, and personalised feedback targeting knowledge gaps and response structure. The platform aims to replicate authentic viva dynamics while providing scalable, time-efficient practice to augment limited consultant-led preparation.

Conclusion: FRCA candidates demonstrate growing AI engagement and clear expectations for exam-aligned, feedback-rich systems. A structured AI viva platform may enhance preparation efficiency and learner confidence within anaesthetic training. Post-trial evaluation is planned following user implementation of FRCA.Ai.

References

1. Royal College of Anaesthetists. Final FRCA Examination Regulations and Guidance. London: RCoA; 2023.
2. Hattie J, Timperley H. The power of feedback. Rev Educ Res. 2007;77(1):81–112.

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Oral Presentations

5. Implementing Dedicated Human Factors Training in the Theatre Environment

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Affiliated to the Royal United Hospital, Bath

Introduction: Guidelines for the implementation of human factors in anaesthesia recommend that education and training should be provided at an appropriate level for all anaesthetists and members of operating theatre teams (1). Additionally, non-technical aspects of human factors are incorporated in the Royal College of Anaesthetists' training curriculum (2). To date, no formal human factors training exists for members of the operating theatre teams. Our aim was to establish and deliver dedicated human factors teaching within theatres to improve the understanding and awareness across all theatre team members.

Methods: Tea trolley training was used to deliver human factors teaching to theatre staff members over a dedicated one-month period at the Royal United Hospital, Bath. The month was split into discrete weeks focussing on four different aspects of human factors: 'teamwork', 'communication', 'freeze, frazzle and flow', and 'optimising performance'. All members of the theatre team were invited to attend teaching – including anaesthetists, surgeons, ODPs, anaesthetic, scrub and recovery nurses and theatre HCAs. Staff were asked to provide feedback on the session and their experience of human factors – these results were collated.

Results: Over the one-month period, 107 teaching episodes received feedback. Results showed that 18.7% of respondents had never had any formal or informal human factors teaching. 97% felt the subject matter was relevant to their role and 89% would use the techniques taught in the sessions. 93% of respondents felt that the teaching would make a positive impact on their future practice. 89% of respondents stated they would value more human factors teaching.

Discussion: We have demonstrated that utilising tea trolley training to deliver human factors training is a reproducible, low-cost, high-impact approach with the intended benefit of improving patient safety, staff safety and overall awareness of non-technical factors of human factors within the theatre environment.

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Oral Presentations

6. Foundation-Year-2 Doctors Reported Benefits to Learning from Organised Non-Core-Teaching

Deanna Yiu, Ellen Hamilton, Varun Deshpande, Warwick Hospital, South Warwickshire NHS Foundation Trust

Introduction: UK resident doctors in foundation training are required to complete 60 hours of teaching annually, 30 of which are 'core' sessions following a national curriculum1. The remaining hours are completed by individuals based on their learning needs. A survey conducted showed 92.3% of FY2 doctors at Warwick hospital felt they would benefit clinically from a 'non-core' teaching programme, the same percentage agreeing this would help them achieve the requirements. This Quality Improvement Project (QIP) evaluates a novel, non-core teaching programme addressing this gap.

Methods: A prospective QIP was conducted using Plan-Do-Study-Act methodology. Following needs analysis, weekly one-hour sessions were organised from December 2025 to present. Feedback was obtained using the Kirk Patrick model of evaluation, using Likert scales to quantify baseline confidence scores, learner reaction and immediate knowledge acquisition. Qualitative feedback underwent thematic analysis2. Statistical analysis used paired t-tests.

Results: Interim analysis of 32 responses demonstrated a statistically significant improvement in self-reported clinical confidence, rising from a pre-session mean of 2.28 (SD 0.99) to 4.63 (SD 0.55). This represents a significant mean increase of 2.35 ($t(31) = 13.91$, $p < 0.001$, 95% CI: 2.01 - 2.69). Notably, 97% of participants confirmed the topics were not covered in core teaching. Thematic analysis identified three strengths of organized non-core teaching: psychological safety, clinical relevance, and active engagement3.
Conclusion: The teaching programme successfully increased resident doctors confidence overall and aided in achievement of non-core teaching requirements. The curriculum will be refined based on outcomes of future PDSA cycles, with handover to junior colleagues for continuation of the program.

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Poster Presentations

1. Can Student-Organised Conferences Improve Understanding of Anaesthesia Training Pathways Among Medical Students and Foundation Doctors?

Alexander Van Loggerenberg, East Midlands School of Anaesthesia

Introduction: Anaesthesia and Intensive Care Medicine represent a small part of many undergraduate medical courses in the United Kingdom. Recent graduates report poor understanding of the specialties' training pathways (Kumar et al., 2023). This study evaluates whether regional student-organised conferences could address this gap.

Methods: As part of a regional student-organised anaesthesia-themed conference, we included a 30-minute talk about hospital anaesthesia and the training pathways for anaesthetics and intensive care. Using a pre- and post-intervention survey design, attendees were asked to rate their understanding of the training pathways on a 5-point Likert scale (1 = not at all, 5 = very well). Attendees also reported their likelihood to pursue a career in anaesthesia or intensive care.
Pre conference data was collected on the booking form with post conference data obtained via digitally distributed feedback forms.

Results: Of a total 56, 22 attendees completed both the pre and post conference surveys, with a mean self-reported increase in understanding of the training pathway from 2.6 to 3.9 ($p=0.024$).
Respondents also rated that they were more likely to pursue a career in anaesthesia and intensive care having attended the conference.

Discussion: This brief survey demonstrates the efficacy of a concise nested presentation within a student-organised conference in both in increasing interest and understanding of the training pathways. Given the small sample size and self-selection of attendees, there are limitations to the generalizability of these findings, but they suggest a promising impact from small local interventions.

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Poster Presentations

2. RDEG: Turning Everyday Challenges into Trust-Wide Solutions

Martyna Jankowska, South Warwickshire University NHS Foundation Trust (SWFT)

Introduction: Resident doctors commonly encounter operational problems that affect patient care, training and wellbeing (e.g., induction variability, rota communication, rest facilities, on-call logistics) [1–3]. National findings highlight workforce strain, including burnout risk and fatigue-related safety concerns [1,3]. During periods of industrial action, reliable local routes for two-way communication and practical improvement are particularly important. We established a Resident Doctors' Engagement Group (RDEG) to translate frontline issues into feasible actions and strengthen constructive doctor - leadership discussions.

Methods: RDEG was formed by doctors in training and locally employed doctors (LEDs), with 16 departmental representatives and defined leads across six pillars (Education, Simulation, Rota, Research, Communications, Wellbeing). Workstreams were aligned to the NHSE10-Point Plan [2]. Initial priorities were informed by national findings [1,3] and a large local LED audit. RDEG established regular meetings with Medical Education and executive decision-makers. Ongoing feedback was gathered via departmental reps, grand rounds and a local resident doctor survey; solutions were co-designed with operational stakeholders (e.g., HR, estates, operations) and communicated back to departments to close the loop.

Results: RDEG established a pathway for resident doctor voice with a standardised escalation process and named owners, improving coordination of work that had previously occurred in departmental silos. Early outputs included: (1) improved induction and onboarding signposting (clearer "who to contact" routes and access to a centralised list of ongoing audits); (2) clarified rota communication pathways; and (3) accessible guidance on rest facilities and on-call logistics, alongside improved signposting to education and simulation opportunities. During recurrent industrial action, the structure supported timely communication between resident doctors and the Trust. Since October, the SWFT NHS England 10-Point Plan survey score increased from 81% to 92%**.**

Conclusion: RDEG is a scalable model that converts everyday frontline challenges into deliverable Trust action through structured representation, clear accountability and sustained doctor - leadership liaison.

References:

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Poster Presentations

3. A Dynamic Delphi for Experiential Learning: Using AI to Transform Research Education for Residents

Davies A[1], Godfrey E[1], Dunn, C[2], Woodhouse, T[3] [1]Critical Care Unit – Cardiff and Vale University Health Board, [2] Anaesthetic Department – Cardiff and Vale University Health Board, [3]Anaesthetic Department – Aneurin Bevan University Health Board

Introduction: Research training is a mandatory component of the Royal College of Anaesthetists and Faculty of Intensive Care Medicine curricula. In Wales, the Welsh Anaesthetic Audit & Research Engagement Network (WAAREN) and Welsh Intensive Care Society Audit & Research Trainees (WICSART) support these curricular requirements through an annual research study day. Artificial intelligence (AI) offers opportunities to enhance postgraduate education, particularly in research training[1], through improved learning design, interactivity and engagement. Despite the Delphi process being a widely used consensus methodology in healthcare research[2], resident knowledge remains limited.

Methods: A peer-facilitated workshop was developed to teach the principles of Delphi methodology whilst simultaneously conducting a live Delphi exercise addressing a meaningful resident-led research question. AI tools supported the production of facilitator guidance, small-group learning materials and simulated qualitative and quantitative data for thematic and statistical analysis.
The workshop was delivered to a mixed cohort of seventy-three anaesthesia and intensive care residents. Objectives included: (1) improving self-reported understanding of the Delphi process; (2) delivering education aligned with curricular requirements; and (3) increasing motivation to participate in resident-led research. Outcomes were evaluated using anonymised pre- and post-event questionnaires, with differences in ordinal responses analysed using the Mann-Whitney U test (one-tailed).

Results: Self-reported knowledge of the Delphi process increased significantly, with 10% of participants rating themselves as ‘somewhat’ or ‘very’ knowledgeable pre-workshop, rising to 97% post-workshop ($p<0.01$). Alignment with curricular requirements was rated as ‘excellent’. Post-workshop likelihood of participation in resident-led research was high (median Likert score 8/10, IQR 2).

Conclusion: This novel AI-enhanced, experiential Delphi workshop represents a viable and effective approach to integrating research methodology teaching with authentic research participation. AI-supported resource development reduced faculty workload and increased learner interactivity. This scalable approach offers a practical framework for strengthening research training and promoting resident-led research within postgraduate medical education.

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Poster Presentations

4. Peer-led Simulation in Anaesthesia: A Novel Approach to a Critical Incident Course.

Daniel Whitney (ST6 anaesthetics, University Hospitals Birmingham) Jonathan Candan (Education fellow, University Hospitals Birmingham) Arif Qureshi (Consultant anaesthetist, University Hospitals Birmingham)

Introduction: Traditional simulation courses incorporate the use of a skilled faculty to facilitate and debrief scenarios. Learners can often feel under faculty induced pressure, which can impede performance and disrupt debrief discussion (1). The peer-led approach reduces nerves, increases confidence, deepens knowledge and improves performance (2). What if we flipped the switch and allowed learners to facilitate and debrief predesigned simulations in addition to observing and participating.

Method: A critical incident course was designed for stage 1 anaesthetic resident doctors addressing curriculum requirements for human factors, critical incidents and simulation. The course began with a series of lectures covering peer-led simulation facilitation and debrief. Each of the 8 resident doctors rotated through being an observer, candidate, facilitator and debriefer across four simulated scenarios (figure 1). The simulations were predesigned with a scenario template given to the debriefier and facilitator with time allocated for preparation. A faculty member provided overall supervision for the facilitator and debriefer. This allowed quick troubleshooting and ensured learner psychological safety was maintained throughout (3). The remaining faculty were allocated roles within the simulation as determined by the facilitator.

Figure 1: Course structure for each resident doctor.
Resident doctors completed a pre and post-course survey addressing the effectiveness of peer-led simulation, confidence in managing critical incidents and the understanding of human factors.

Results: Following the course all resident doctors understood the role of human factors in healthcare. Learner confidence in managing critical incidents increased from 37.5% (pre-course) to 100% (post-course). Residents doctors were all in agreement that peer-led simulation increased their learning, with 67.5% reporting peer-led to be superior, when compared with faculty-led. Peer-led simulation was found to be less stressful than faculty-led for 75% of learners.

Conclusion: Peer-led simulation in anaesthesia is an engaging and effective educational tool. It increases candidate learning and is non-inferior or superior to faculty-led simulation.

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Poster Presentations

5. A Multimodal, Small-Group Lunchtime Programme to Improve Confidence in Paediatric Regional Anaesthesia

Bhalla N[1], Hansell R[2] [1]Anaesthetic ST6, Cardiff and Vale University Health Board [2]Anaesthetic ST7, Cardiff and Vale University Health Board

Introduction: Following the introduction of Paediatric Plan A blocks by Regional Anaesthesia UK (1) and emerging data from the Paediatric Regional Anaesthesia Network (2,3), there is an increasing need for accessible training in paediatric regional anaesthesia. Clinical pressures often limit attendance at formal teaching. We developed a monthly, small-group lunchtime regional anaesthesia programme using a multimodal teaching approach to address this gap.

Methods: Monthly sessions were delivered by two anaesthetic registrars with specialist interest training in regional anaesthesia. Sessions lasted 3–4 hours and were designed to allow opportunistic attendance alongside clinical duties. Teaching modalities included live ultrasound scanning on volunteer models, needle trainer practice, phantoms for needling and vascular access, and anatomy applications. Multiple learning stations were used to maximise hands-on time and reduce waiting. Participant confidence in specific regional techniques was assessed using pre- and post-session feedback forms.

Results: All participants (100%) rated the sessions as useful and requested further sessions. Phantoms were rated as beneficial by 100% of attendees. The needle trainer was rated as useful by 91% of participants; reduced utility was attributed to technical difficulties during one session. Self-reported confidence improved across all regional techniques taught, with marked increases demonstrated between pre- and post-session assessments (Figure 1). A focused abdominal wall regional anaesthesia session covering quadratus lumborum, transversus abdominis plane, ilioinguinal/iliohypogastric, external oblique intercostal, and paravertebral/erector spinae blocks received particularly positive feedback.

Discussion: This multimodal, small-group lunchtime programme provides a flexible and effective model for delivering paediatric regional anaesthesia education. It supports learners across a range of experience levels, facilitates peer learning, and allows teaching to be tailored to learner needs. Future sessions will expand to upper limb regional anaesthesia, free-scanning workshops, and increased access to paediatric models during school holidays.

Figure 1: Confidence levels of attendees before and after the meeting with specific blocks.

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Poster Presentations

6. Beyond Confidence: A Supervised Ultrasound-Guided Vascular Access Training Pathway in Day Surgery Unit

William Harper, ACCS CT2 Anaesthetics, Royal United Hospital, Bath

Background: Anaesthetic teams are frequently called to manage difficult IV access, with data from our anaesthetic department demonstrating approximately 80 cannulation requests per month. While ultrasound-guided vascular access (USVA) teaching is increasingly delivered to ward-based doctors, unsupervised early practice risks overconfidence without competence, potentially increasing complications and continued reliance on anaesthetic support. We therefore developed a supervised training pathway emphasising safe skill consolidation within the perioperative setting.

Methods: Part 1 comprised a half-day face-to-face teaching session aligned with the FAMUS vascular access curriculum, supported by pre-course online modules. Seventeen non-anaesthetic resident doctors attended. Part 2 involved supervised USVA in the Day Surgery Unit (DSU), where patients were cannulated ahead of their elective procedures. Over six weeks, eleven of the seventeen participants progressed to supervised clinical practice, performing ultrasound-guided cannulations under direct supervision prior to theatre transfer. Pre- and post-course questionnaires assessed self-reported knowledge, confidence and overall ability. Consultant anaesthetists were also surveyed regarding perceived impact on theatre efficiency.

Results: Participants demonstrated a 32% increase in self-reported confidence, 22% increase in knowledge and 28% increase in overall USVA ability. 86% of consultant anaesthetists also agreed that proactive DSU cannulations improved theatre efficiency and reduced delays for patients with difficult IV access.

Discussion: A supervised consolidation phase within DSU differentiates this programme from traditional workshop-based teaching alone. By prioritising competency development within a clinical environment, this model seeks to promote safe independent practice. The model also has a potential system-level impact by improving theatre efficiency. Next steps include evaluating whether the programme reduces overall cannulation requests and collecting quantitative data on theatre list efficiency.

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Poster Presentations

7. Improving the Educational Value of Theatre Lists using Vascular and Neuroanaesthesia 'Padlets'

Dr. Jordan M Sudworth - Consultant Anaesthetist - Hull University Teaching Hospitals NHS Trust

Introduction: Anaesthetic residents spend much of their training working under the direct supervision of a consultant anaesthetist. Opportunities to teach in theatre, however, may be hampered for a number of reasons including high-turnover lists, challenging patients or a lack of preparation by the trainer or resident. I created a number of digital educational resources to improve the quality of in-theatre education whilst minimising the burden of preparation for trainers.

Method: I created two educational tools[1,2] using Padlet software[3] for residents seeking to meet their Vascular and Neuroanaesthesia learning objectives. Residents are able to access the tool by scanning a QR code. Once accessed, residents can easily review educational articles, videos and other resources specifically designed to meet their learning objectives. In addition, there are a number of tailored case-based discussions that can be reviewed with the trainer to reinforce learning. Residents and trainers can give feedback using an embedded link.

Results: 22 residents completed feedback. 86% (19/22) of residents felt the educational tool was useful or very useful in signposting to the curriculum and learning resources. 90% of residents (20/22) felt the tool improved the quality of education during the theatre list.
18 trainers completed feedback. 94% (17/18) of trainers felt the padlet improved the quality of education during the list whilst also making it easier to deliver a list with educational value.

Conclusion: It can be challenging to ensure all anaesthetic lists have educational value. By creating an easily accessible, well designed and organised digital reservoir of learning resources, one can improve the quality of education in-theatre without creating excessive burden on the trainer.

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Poster Presentations

8. All at C! Confidence and Competence in Chest Drain in Critical Care

Dr Rhian Pembridge (Foundation Year 2 Doctor CRH), Mr Ben Rees (Surgical Registrar Yorkshire), Dr Emma Searle (Consultant Anaesthetist UHDB)

Introduction: Chest Drain Insertion (CDI) is a core skill within critical care. The British Thoracic Society (BTS) describes the need for adequate training.[1] Research advises that procedural guidelines should highlight specific 'subtasks' most vulnerable to error and that training promotes safe performance.[2]

Methods: We undertook three steps to improve CDI safety. Firstly, we evaluated clinician's confidence before and after a CDI simulation teaching session. Secondly, we distributed staff surveys evaluating doctors' and nurses' confidence and competence in CDI. Thirdly, we examined equipment and documentation on critical care after a previous intervention to check adherence and utilisation.[3]

Results: Firstly, pre-teaching, 25% of doctors felt comfortable in CDI, post-teaching this reached 100%. The median comfort rating in inserting drains on a Likert scale of 1-10 increased from 1.5 pre-teaching to 5.5 post-teaching. Pre-teaching, 50% of doctors self-reported that they knew the equipment needed, showing initial uncertainty. This increased to 100% post-teaching.
Secondly, the survey illustrated that 100% of nurses knew where to find CDI equipment, but 73% of doctors were unsure or incorrect. 93.5% of all respondents felt there was benefit from further teaching, with comments including requests for suturing and CDI complications.
Finally, the procedural equipment and CDI checklist, with the triangle of safety highlighted, were absent. However, the documentation proforma persisted, and CDI equipment was present, labelled and had a checklist for re-stocking the trolley.

Conclusion: Simulation teaching improves confidence in CDI. These results show residents and nurses wanted more training. Further, clinicians were unsure about CDI equipment storage, and a previous intervention had stalled.
We recommend further simulated CDI teaching with the new inclusion of suturing techniques. Furthermore, reinstatement of equipment reference sheets in conjunction with new pre-assembled packs to optimise competence and confidence in chest drains on critical care.

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Poster Presentations

9. Evaluating Training Exposure and Case Mix for Final FRCA Structured Oral Examination Preparation: A Survey-Based Analysis

Dr Bejal Patel, Dr Shilpi Sethi and Professor Cyprian Mendonca

Introduction: Preparation for the Final Fellowship of the Royal College of Anaesthetists (FRCA) Structured Oral Examination (SOE) requires completion of curriculum-mandated modules alongside exposure to complex clinical scenarios across various subspecialties.[1] [2] Variability in training opportunities may impact perceived readiness and confidence for this high-stakes oral assessment. This survey evaluated training grade, module completion, and subspecialty case exposure among candidates, with a focus on cardiothoracic and neuroanaesthesia.

Methods: A paper based survey was distributed to candidates attending a preparation course held two weeks prior to the Final SOE. The survey captured: (1) Trainee grade and completion of mandatory modules, (2) Number and type of cardiothoracic anaesthesia cases and (3) Number and type of neuroanaesthesia cases completed. Module completion was analysed across five subspecialty domains: paediatrics, neuroanaesthesia, cardiothoracic, obstetric anaesthesia and pain medicine.

Results: Data were collected from 44 candidates working in posts across the United Kingdom, with a response rate of 88%. Respondents were predominantly Stage 2 trainees, in recognised training programmes. Only 20% of candidates had completed all subspecialty modules across the five domains. While 50% had completed at least one module in either cardiothoracic or neuroanaesthesia**.** Despite module completion, substantial variability in clinical exposure was observed. Cardiothoracic case numbers varied widely: 47% of candidates had been exposed to cardiopulmonary bypass cases, and only 41% had undertaken a cardiac catheter laboratory procedure. Neuroanaesthesia exposure was similarly inconsistent, with only 36% having performed an emergency craniotomy. Even fewer candidates reported experience in higher-complexity cases such as posterior fossa surgery and neuroradiology procedures.

Conclusion: Although many candidates demonstrate engagement with curriculum module completion, marked variability in subspecialty case exposure persists. While this sample size may not be representative of all candidates across the United Kingdom, it provides an indication of trainee subspecialty module completion and clinical exposure prior to the SOE. From a medical education perspective, these findings suggest that module completion alone may not fully reflect preparedness for high-stakes assessment. Consideration of enhanced subspecialty access, closer curriculum–assessment alignment, and the use of structured simulation may help support more consistent preparation for the Final FRCA SOE.[3]

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Poster Presentations

10. Learning from Excellence: Implementing a Positive Feedback Initiative in Critical Care

Kellan Masharani[1], Katie Essak, University Hospital Coventry & Warwickshire NHS Trust

Introduction: Healthcare improvement traditionally focuses on adverse events, however, most clinical care is successful. Learning from excellence has been proposed as an alternative and additional approach that may strengthen morale, professional development and team culture[1,2]. Staff in critical care are at increased risk of burnout, and barriers such as hierarchy and time pressures may limit positive feedback. We evaluated a structured positive feedback initiative ("Kudos") within a critical care unit.

Methods: A unit-wide initiative enabled all staff, regardless of role or seniority, to submit positive feedback recognising clinical practice, teamwork and teaching via a "Google Form" accessed through a QR code. The same form included optional evaluation questions exploring how often respondents received positive feedback, its perceived importance, and whether receiving Kudos feedback influenced their sense of being valued. Responses were collated automatically within Google Forms over 12 months. Quantitative data were summarised using percentages and free-text comments were reviewed to identify recurring themes.

Results: Eighty positive feedback entries were received over 12 months. Among optional respondents, 57% reported receiving positive feedback only occasionally and 34% rarely. 6% reported never receiving feedback and only 3% very frequently (n=35). Positive feedback was rated very or extremely important by 60% (n=35). Regarding perceived value at work (n=34), 53% felt somewhat valued, 27% valued, 18% highly valued and 3% not at all valued. Among those receiving Kudos feedback (n=28), 82% reported feeling more valued as a team member. Qualitative responses highlighted improved morale, motivation and cross-hierarchical recognition.

Conclusion: This low-cost, structured positive feedback initiative demonstrated strong engagement and perceived benefit. Learning from excellence may represent a practical strategy to enhance wellbeing and foster a positive educational and clinical culture within critical care.

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Poster Presentations

11. Designing a Fairer, Safer Anaesthetic Resident Doctor Rota: A Trainee-Led Quality Improvement Project Enhancing Resident Anaesthetist's Training

Dr Sammy Sharif - ST6 Anaesthetics, University Hospital Wales, Dr Neeta Tailor - Consultant Anaesthetist, Royal Glamorgan Hospital

Introduction: Rota design plays a critical role in wellbeing, educational opportunity, and patient safety. At the Royal Glamorgan Hospital (RGH), anaesthetic resident doctors reported significant dissatisfaction with the existing rota. A baseline survey in February 2024 highlighted unclear rules, unpredictable scheduling, and delays or rejections of annual and study leave. These concerns were reflected in the 2024 National Training Survey (NTS), where RGH received poor scores for rota satisfaction. This project aimed to co-design a fairer and more transparent rota system that supported both wellbeing and training.

Methods: Using iterative PDSA cycles and working in collaboration with consultants, service managers, and HR; three main interventions were introduced:

1. Creation of a comprehensive Rota Policies and Induction document.
2. Digitalisation of rota swaps and educational development time requests.
3. Replacing the existing rolling rota system with a request-based rota system.

Both local survey data and NTS results were analysed to assess improvement.

Results: Rota design satisfaction scores as per the NTS improved from 46.63/100 in July 2024 to 71.09/100 in July 2025 - an improvement of almost 25 points. FIgure 1 demonstrates the NTS scores for a multitude of areas pre and post interventions. From local survey data, reported ease of obtaining annual leave increased from 3.6/10 to 8/10, and study leave from 4.3/10 to 7.4/10. Annual leave rejections fell by 70%, study leave rejections by 40%, and inappropriate on-call allocations by 80%.

Discussion: This project illustrates the power of trainee-led, data-driven QI in delivering meaningful cultural and operational change. Key enablers were senior sponsorship, stakeholder engagement, and transparent communication. This project serves as a model for how small, well-structured QI initiatives can lead to tangible, lasting change within the NHS when collaboration, clarity, and co-production are at their core.

			Survey Year	2022		2023		2024		2025	
Post specialty	Trust/board	Site	Indicator	Score	Outcome	Score	Outcome	Score	Outcome	Score	Outcome
Anaesthetics	Cwm Taf Morgannwg University Local Health Board	The Royal Glamorgan Hospital - 7A5B1	Overall Satisfaction	88.18	Within IQR	87.50	Within IQR	81.92	Within IQR	86.25	Within IQR
			Clinical Supervision	95.91	Within IQR	95.50	Within IQR	89.71	Q1 but not below	93.75	Within IQR
			Clinical Supervision out of hours	90.97	Within IQR	97.22	Within IQR	94.32	Within IQR	95.54	Within IQR
			Reporting Systems	74.88	Within IQR	81.67	Within IQR	70.63	Within IQR		N less than 3
			Workload	60.42	Within IQR	59.79	Within IQR	51.76	Within IQR	80.27	Above
			Teamwork	79.55	Within IQR	84.17	Above	75.64	Within IQR	84.38	Within IQR
			Handover	62.50	Within IQR	69.44	Within IQR	54.69	Below	63.19	Within IQR
			Supportive Environment	83.18	Within IQR	86.00	Within IQR	78.46	Within IQR	88.13	Within IQR
			Induction	88.18	Within IQR	85.50	Within IQR	63.85	Below	86.25	Within IQR
			Adequate Experience	87.50	Within IQR	85.00	Within IQR	84.62	Within IQR	87.50	Within IQR
			Educational Governance	77.27	Within IQR	81.67	Within IQR	71.79	Within IQR	90.62	Within IQR
			Educational Supervision	90.34	Within IQR	96.88	Within IQR	89.42	Within IQR	96.88	Within IQR
			Feedback	82.08	Within IQR	91.67	Within IQR	73.75	Within IQR	86.56	Within IQR
			Local Teaching	74.07	Within IQR	78.52	Within IQR	71.97	Within IQR	48.09	Q1 but not below
			Regional Teaching	54.17	Within IQR	58.80	Within IQR	59.85	Within IQR	63.69	Within IQR
			Study Leave	59.95	Within IQR	56.02	Within IQR	47.50	Below	66.07	Q1 but not below
			Rota Design	71.02	Within IQR	73.75	Within IQR	46.63	Below	71.09	Within IQR
			Facilities	66.50	Within IQR	69.84	Within IQR	77.95	Within IQR	90.00	Above

Figure 1. National Training Survey Results. The yellow star represents our primary outcome measure with the black rings around the 2024 and 2025 scores.

Poster Presentations

12. Remote Mentoring as Part of a Hybrid Educational Model for Accreditation in Basic Transthoracic Echocardiography: Experience and Efficacy of a Novel Approach

Thomas Sanderson University Hospitals Bristol and Weston, Steven Coulson University Hospitals Bristol and Weston, Theophilus Samuels Surrey and Sussex Healthcare Trust, Alice Myers, Surrey and Sussex Healthcare Trust

Introduction: Focussed transthoracic echocardiography (fTTE) is increasingly used in anaesthesia and intensive care, with demonstrated benefits in diagnosis and haemodynamic monitoring[1]. Accreditation is commonly achieved through the Focussed Ultrasound in Intensive Care Echocardiography (FUSIC Heart) programme, relying on face-to-face supervision. However, clinical workload and trainee rotation between centres limits access to consistent mentorship. This study explored learner experience of a hybrid training model incorporating group-based remote mentoring alongside traditional teaching.

Methods: Learners undertaking fTTE training received bedside supervision for early scans and completed relevant eLearning. Remote mentoring was subsequently delivered via small WhatsApp groups, where learners shared deidentified images and reports. An expert mentor provided feedback visible to all group members. Learner experience was explored using structured open-question questionnaires and analysed using phenomenological thematic analysis. A pre-study bracketing interview was conducted to minimise researcher bias.

Results: Twelve learners completed the questionnaire, reporting that 25–90% of their mentored scans were reviewed remotely. Five major themes emerged. Participants reported improved access to feedback, flexible engagement, and opportunities for shared learning. The approach supported asynchronous participation, enabled a permanent record of feedback, and mitigated barriers related to clinical workload and rotations.

Theme	Sub-themes
Balancing clinical duties and fTTE mentorship commonly impedes training.	Mentors may struggle taking on new learners, having to balance other responsibilities.
	It is often extremely difficult finding time where both mentor and learner are available to review scans during a shift.
	It is common for learners to sacrifice rest time (e.g. days-off) to meet with a mentor.
Real-world constraints can limit educational efficacy of face-to-face mentorship.	Mentor and learner's time can often be limited by clinical duties, making sessions feel rushed.
	Scans are often reviewed "in bulk", allowing error to be repeated rather than correcting early.
	Detailed feedback is often spoken word only, with limited written feedback to review later in training.
	Technical issues with saving and retrieving training scans can present difficulties.
Remote mentoring removes some real-world limitations.	No time constraints: mentors can review scans at time of their choice, learners can post questions in real time.
	Written feedback can be just as detailed, and is recorded more robustly for later review
	Extra evidence or material to read/watch can be easily linked to feedback.
Group based learning offers significant opportunities.	Learners review a much higher volume of scans, improving image interpretation practice
	Learners may be exposed to rarer pathology they may otherwise miss in training
	Seeing another learner's feedback can be applied to your own learning
	Seeing other learners make similar mistakes can offer reassurance during the initial steep learning curve of fTTE
Some limitations to remote mentoring.	Understanding and applying feedback on practical scanning technique can be difficult
	Sharing scans performed early on in training can initially feel intimidating to some learners

Table 1: overarching descriptive themes and their corresponding sub-themes, generated from learner responses to questionnaires on fTTE mentorship experience.

Discussion: Despite limitations including a small sample size, this study suggests that hybrid fTTE training incorporating remote group-based mentorship is acceptable to learners and enhances training accessibility and continuity. The findings can be interpreted through an andragogical framework, in which adult learners are self-directed and motivated by autonomy; the remote model enabling learner control over the timing, and depth of engagement with feedback[2]. Furthermore, the delivery of brief, asynchronous feedback reflects microlearning theory: facilitating knowledge acquisition through concise, contextually relevant interactions embedded within clinical practice[3]. Together, these theoretical perspectives provide an explanatory basis for the perceived effectiveness of the intervention and support a hybrid model of mentorship to meet growing demand for echocardiography accreditation.

References:

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Poster Presentations

13. Introducing the BJA Education Forum: A Sustainable, Low-Preparation Model for Departmental Anaesthetic Teaching

M.Roach, E.Perritt Department of Anaesthesia, Countess of Chester Hospital, England.

Introduction: Delivering consistent departmental teaching in anaesthesia is frequently hindered by clinical pressures and the "preparation burden" on faculty and trainees. Our baseline assessment identified that 100% (n=9) of clinicians had previously felt reluctant to lead sessions due to the time-intensive nature of traditional didactic methods. We developed the BJA Education Forum to address these barriers while maintaining educational rigour.

Methods: We implemented a fortnightly 60-minute, discussion-based session centred on a single BJA Education article. The format required no pre-reading for participants and minimal facilitator preparation. Following implementation, we surveyed the department (n=9; 77.8% trainees, 11.1% SAS, 11.1% consultants) to evaluate the model against traditional PowerPoint-led teaching using 5-point Likert scales (1 = strongly disagree, 5 = strongly agree) and qualitative feedback.

Results: The BJA Education Forum significantly reduced barriers to teaching:
• Sustainability: 55.5% of respondents required >3 hours for a traditional lecture, compared to 100% requiring <60 minutes for the Forum model (22.2% <15 minutes, 55.5% <30 minutes).
• Educational Quality: 77.8% rated BJA Education articles as more reliable/higher quality than custom slide decks, with the remainder rating them equal. 100% felt the sessions were more relevant to their daily practice (66.7% rating 5/5, 33.3% rating 4/5).
• Clinical Impact: 44.4% reported that discussions directly influenced a clinical decision in theatre, the remainder anticipating future impact.
• Psychological Safety: 100% (scoring 5/5) agreed the format made them more comfortable sharing clinical uncertainties regardless of grade.
• Engagement: 100% rated the Forum as more engaging than traditional teaching (77.8% scoring 5/5).

Conclusion: The BJA Education Forum represents a paradigm shift from high-maintenance lectures to high-impact peer discussion. By utilising peer-reviewed, curriculum-aligned literature, the model ensures educational rigour while virtually eliminating the preparation barrier. This model is highly replicable, fosters a psychologically safe environment for cross-grade clinical debate, and shows direct translation to clinical practice.

Poster Presentations

14. Independent Practice in Anaesthetic Training: Exploring Trainee Experiences and Trainer Perspectives: An Educational Evaluation

Dr Sanjeev Sahota, Anaesthetic Clinical Fellow (UHSussex East), MSc Clinical Education Student (Brighton and Sussex Medical School), Dr Thomas Mount, Anaesthetic Consultant (UHSussex East)

Introduction: Anaesthetic training relies heavily on direct supervision. Expansion of consultant-delivered services has reduced opportunities for Anaesthetists in Training (AiT) to practice independently, despite curriculum requirements for competence in autonomous practice[1]. The Royal College of Anaesthetists (RCoA) recommends 1 indirectly supervised full day lists every 2 weeks from CT2, increasing in Stage 3 to approximate a consultant workload[2]. Nationally, concerns persistent regarding inconsistent exposure and trainee preparedness.

Methods: A cross-sectional survey of AiT across 6 Sussex hospitals (June-July 2025) examined frequency of solo and distantly supervised lists, perceived preparedness for independent practice, and consultant perspectives. Ethical approval was obtained from the Brighton and Sussex Medical School RGEC.

Results: 64 AiT (45.1%) and 86 consultants (43%) responded. Median solo list frequency across all stages was less than once every 6 months and median distantly supervised lists was once every month. Compared with RCoA recommendations, 89% of AiT undertook solo lists and 75% undertook distantly supervised lists less frequently than once every 2 weeks. Greater frequency of solo ($\tau = 0.41$, $p < .001$) and distantly supervised ($\tau = 0.53$, $p < .001$) exposure correlated significantly with higher self-reported preparedness. Consultants who trained more recently reported lower exposure to solo lists ($\tau = 0.53$, $p < .001$), lower perceived preparedness ($\tau = 0.54$, $p < .001$), and greater desire for additional solo experience ($\tau = 0.42$, $p < .001$). 81% believed current AiT have insufficient solo exposure and only 26% correctly identified RCoA recommendations. Qualitative analysis identified structural barriers, supervisor-trainee dynamics, and autonomy as central to professional development.

Discussion: Supervised autonomy falls far short of national standards as is strongly linked to readiness for consultant practice. Without structural change, training risks producing consultants who are competent but not confident. We are expanding solo list allocations and piloting structured ALMAT lists with qualitative analysis to address this gap.

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Table 1: Frequency of Solo and Distantly Supervised Lists Stratified by Stage of Training
(Solo = consultant in another theatre or co-ordinating; Distantly supervised = consultant listed as same theatre on CLW, not directly present but available if required)

	Type of List	Median	Skewness	% Less frequent than RCoA Guideline
Stage 1 (n = 18)	Solo	Less than once every 6 months	2.174	100%
	Distantly Supervised	Once every 2 – 3 months	0.208	88.9%
Stage 2 (n = 30)	Solo	Less than once every 6 months	0.706	80%
	Distantly Supervised	Once every 2 – 3 months	0.564	73.4%
Stage 3 (n = 16)	Solo	Once every 2 – 3 months	0.825	93.7%
	Distantly Supervised	Once every month	-1.100	62.4%

Poster Presentations

15. Improving Efficiency and Engagement in Curriculum Progress Tracking: A Tool for Core Anaesthetic Trainees

Dr Samuel Cowley - CT3 Anaesthetic trainee – St Richard's Hospital (SRH) University Hospitals Sussex

Introduction: Core anaesthetic trainees must evidence progression across 54 Key Professional Capabilities (KPCs) within the Lifelong Learning Platform (LLP), including achievement of defined supervision levels. The volume and structure of the curriculum make progress tracking challenging and time-consuming. To improve clarity and support trainees in identifying their training needs, a structured spreadsheet-based curriculum progress tracker was developed and introduced.

Methods: Core trainees at St Richard's Hospital completed a Likert-scale survey (1 = strongly disagree, 5 = strongly agree) assessing self-reported understanding of KPCs, ability to navigate LLP, confidence tracking supervision levels, and confidence identifying portfolio gaps. Following baseline assessment, trainees received the progress tracker, incorporating visual guidance for locating KPCs within LLP. A repeat survey was conducted four months later. Surveys were anonymous and not linked at an individual level; therefore, pre- and post-intervention responses were analysed as independent samples using a Mann–Whitney U test.

Results: Nine trainees responded. Post-intervention scores were significantly higher across all domains. Median scores increased from 3 to 5 for understanding KPCs ($p=0.0067$) and locating KPCs within LLP ($p=0.0032$), and from 2 to 5 for confidence tracking supervision levels ($p=0.0061$) and identifying portfolio gaps ($p=0.0024$). Seven of nine trainees strongly agreed the tool saved time, and eight of nine would recommend it to colleagues.

Conclusion: A structured progress tracker was associated with significantly greater trainee confidence in navigating LLP and monitoring supervision levels. This simple intervention may enhance engagement with curriculum progression and support more focused supervisory meetings while encouraging active ownership of learning requirements. Next steps include wider implementation and evaluation with feedback from educational supervisors.

Poster Presentations

16. Educational Impact of a Pre-Conference Ultrasound-Guided Regional Anaesthesia & Advanced Airway Skills Workshop for Senior Anaesthetists

Dr. Snigdha A Mahajan, Dr. Aaqid Akram, Dr. Sanjay Bhandari, Dr. Cyprian Mendonca, Dr. Veena Daga

Background: RA-UK advocate universal proficiency in Plan A regional anaesthetic blocks, whilst the 2025 DAS Guidelines emphasise ongoing education in advanced airway management.[1,2,3] Despite their clinical importance, senior anaesthetists frequently report limited exposure to these skills in routine practice, highlighting an educational gap that may compromise patient safety and adherence to contemporary guidelines.

Methods: Twenty-seven responses from senior anaesthetic clinicians (specialty trainees, SAS doctors, and consultants) who attended a full-day, hands-on workshop immediately preceding a national conference, were analysed. The programme comprised two sessions: Plan A regional blocks and advanced airway skills. Teaching methodology emphasised supervised ultrasound scanning on volunteers and model-based skill practice following brief lecture presentations and expert demonstrations. Pre- and post-course questionnaires assessed baseline experience and confidence using an 11-point numeric rating scale (0-10) and were subsequently collapsed to validated Likert scales for analysis; responses varied in number across skill domains.

Results: Baseline data revealed infrequent clinical utilisation of taught skills. No participant performed Plan A blocks daily; the majority used them fewer than six times annually. Erector spinae plane (ESP) blocks demonstrated the lowest baseline familiarity (48% reporting no clinical use; 67% expressing poor confidence). Advanced airway skills were underutilised, with 56% lacking confidence to clinically perform neck ultrasound. Post-intervention assessment demonstrated significant improvements in mean self-reported confidence across all domains (Figure 1), with greatest improvements observed for ESP, Rectus Sheath blocks and Ultrasound Neck – increased by approximately 1.2-1.6 points on the 5-point scale. All participants rated the workshop as valuable for professional development and reported enhanced readiness to teach these skills.

Conclusion: A focused, simulation-enhanced workshop integrated within a national conference format effectively addresses confidence deficits in essential anaesthetic skills among senior practitioners. This educational model demonstrates the value of opportunistic, high-quality procedural training for maintaining professional competence and subsequent teaching capability, in accordance with contemporary clinical guidelines.

Figure 1 shows Pre- and Post-course mean confidence scores using a 5-point Likert scale across regional anaesthesia and airway management skills.

Skill (Regional Block/Airway)	Mean Before (SD)	Mean After (SD)	Mean Change
Interscalene Block	2.95 (1.23)	3.56 (1.46)	+0.61
Axillary Brachial Plexus Block	2.71 (1.10)	3.38 (1.54)	+0.67
Rectus Sheath Block	2.86 (1.45)	4.50 (1.40)	+1.64
Femoral Nerve Block	3.10 (1.37)	3.69 (1.40)	+0.59
Adductor Canal Block	2.67 (1.32)	3.56 (1.36)	+0.89
Popliteal (Distal Sciatic) Block	3.23 (1.46)	3.63 (1.41)	+0.40
Erector Spinae Block (ESP)	2.19 (1.25)	3.44 (1.36)	+1.25
Awake Tracheal Intubation	2.48 (1.48)	3.11 (1.29)	+ 0.63
VAF Intubation	2.70 (1.33)	3.33 (1.28)	+ 0.63
Video Laryngoscopy	3.66 (1.43)	2.39 (1.38)	- 1.27
Intubation via Supraglottic airway Device	2.93 (1.29)	3.61 (1.33)	+ 0.68
US neck	2.41 (1.3)	3.61 (1.3)	+ 1.20

References:

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Poster Presentations

17. H.A.L (Higher anaesthetic learning): Your Personal FRCA Tutor – Transforming Anaesthetic Education through Large Language Models

Dr Tom Ratcliffe Law ST-5 University Coventry and Warwickshire

Introduction Since the public release of ChatGPT, Large Language Models (LLMs) have permeated medical education, offering unprecedented opportunities for personalized learning (1). For anaesthetists in training, the rigorous FRCA examination demands not only vast knowledge but also the ability to synthesize complex physiological and pharmacological concepts under pressure. We developed a simple to use chatbot called "HAL,". The use of various resources and simple prompts it was used as a framework for utilizing LLMs as a bespoke, 24/7 tutor tailored to the specific demands of the FRCA syllabus.

HAL leverages the generative power of LLMs to address three critical areas of exam preparation:

- **Tailored Teaching:** LLMs allow candidates to curate their own learning styles. By utilizing "Explain Like I'm Five" (ELI5) prompting, vivid metaphors, and descriptive prompts for diagrams, complex topics—such as the physics of vaporizers or the oxyhaemoglobin dissociation curve—are demystified into digestible narratives. The use of different learning styles for adaptation such as socratic learning. Allowing life long understanding.
- **Adaptive Revision:** Beyond passive reading, HAL acts as a sophisticated tool for active recall. It can instantaneously summarize lengthy clinical papers and generate Constructed Response Questions (CRQs) and Single Best Answers (SBAs) aligned with the RCoA curriculum.
- **Examining & Viva Practice:** Perhaps most transformational is the use of vocal-interface LLMs to simulate the viva exam. This allows for repeated, high-stakes practice in a low-stakes setting, providing candidates with instant feedback on their communication and clinical reasoning.

Conclusion As LLM capabilities continue to improve exponentially, the role of the educator must evolve. HAL represents a shift toward an individualized, on-demand educational model. While human mentorship remains irreplaceable, LLMs provide a scalable solution to the "24/7" revision needs of modern trainees. This poster explores some of the early and practical implementation of these tools, their current limitations, and their potential to democratize elite-level exam coaching for all anaesthetists.

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Poster Presentations

18. Expanding Regional Anaesthesia for Acute Pain Management of Rib Fractures in the Emergency Department at North Bristol Trust

Dr Yolande Squire Anaesthetic ST7 Severn Deanery, Dr Connie Chen Anaesthetic ST7 Severn Deanery
Dr Lauren Bose Emergency Medicine ST7 Severn Deanery, Dr Ruth Greer Consultant Anaesthetist NBT
Dr Chris James Consultant Anaesthetist NBT

Introduction: The erector spinae plane (ESP) block is a well recognised regional anaesthesia technique with applications for acute pain management in patients with rib fractures[1]. Our aim was to improve early access to safe and effective analgesia in select patients. We developed an interdisciplinary teaching and service development program to support the rollout of a single-shot ESP block service at North Bristol, including training for Emergency Department consultants.

Methods: A structured educational program was designed collaboratively between the Department of Anaesthesia and the Emergency Department (ED). This comprised three components: (1) pre-teaching slide-based sessions covering indications, anatomy, contraindications, safety, and governance; (2) supervised practical ultrasound scanning workshops focusing on sonoanatomy, needle visualisation using scan nav and ESP model; and (3) post-teaching clinical supervision, with real-time support during initial independently performed blocks. Teaching was delivered to ED consultants to facilitate safe adoption within emergency care pathways.

Results: Following teaching, participants reported increased confidence in ultrasound identification of ESP anatomy and procedural performance. 100% of participants reported the teaching package as ‘useful ’or ’very useful’. Early clinical adoption demonstrated the feasibility of safe interdisciplinary care delivery with appropriate oversight and governance structures.

Conclusion: An interdisciplinary, structured teaching model incorporating structured reading, hands-on ultrasound training, and supervised clinical practice can safely support the expansion of regional anaesthetic techniques beyond anaesthesia-led care. This approach promotes skill transfer, service resilience, and improved patient access to regional analgesia within the ED.

References:

1. Gawel et al. (2026) Ultrasound Guided Erector Spinae Plane Block for Pain Management in the Emergency Department: A Scoping Review. The Journal of Emergency Medicine Jan 26. Vol 80 pp95-103

Poster Presentations

19. Anaesthetics or ICM first in ACCS CT2? Perspectives Across the West Midlands

Dr James Baker, ACCS Anaesthetics CT3 and ACCS trainee representative, West Midlands, Dr Jem Holland, ACCS Anaesthetics CT2, West Midlands, Dr Ratidzo Danha, ACCS TPD, West Midlands

Introduction: ACCS CT2 doctors complete six-month placements in anaesthesia and intensive care medicine (ICM). Which should come first? We asked last year's CT2s in the West Midlands, and took the results to their College Tutors.

Method: We emailed all (55) of last years' ACCS CT2 trainees in the West Midlands with a survey. We asked their hospital, their parent specialty (Anaesthetics, Emergency Medicine (EM) or Internal Medicine (IM)), which placement they did first, how they would have chosen and why. We took the results of this first survey to the West Midlands College Tutors, asked their hospital/trust, and how they currently arrange CT2 placements for each parent specialty and why, and how our results have influenced their practice.

Results: For residents, we had respondents across nine hospital trusts. 79% had Anaesthetics and 21% had EM as a parent specialty. 93% would have opted for Anaesthetics first. Most common reasons for this were: gaining knowledge/skills for ICM; and greater contribution to the service. Most reported minimal/no drawbacks to completing anaesthesia first.
For College Tutors, we had respondents across five trusts. 40% said that the results of the CT2 survey has informed them further on preferences for placement chronology. For ACCS Anaesthetics CT2s, 80% of these College Tutors would put Anaesthetics first where possible, the other being equally split, citing small ITU size for the reason, to preserve access to ICM training opportunities. For EM and IM trainees there was an equal split between Anaesthetics and ICM first.

Discussion: Our findings suggest agreement between trainees and College Tutors: ACCS CT2s benefit from completing anaesthetics before ICM for educational and service benefits. Where logistical constraints prevent this, targeted alternatives can preserve the effectiveness of the CT2 year – we hope this work encourages local and regional conversations on how best to go about this.

Poster Presentations

20. Infographics for the Non-Paediatric Anaesthetist

Kate Taylor, Clare Abeysekara, Patrick Walker (Severn Deanery Anaesthetic Registrars)

Introduction: Children undergoing anaesthesia for surgery pose a range of challenges. With the centralisation of services alongside timing of paediatric rotations, LTFT training and a national reduction in caseloads we see fewer paediatric cases out-of-hours in DGHs, further reducing familiarity and timely experience, especially in those children requiring emergency surgery and those who are critically unwell.

Aims: We aimed to develop a set of infographics to offer education and quick reference support for trainees, trust grade doctors and consultants less familiar with anaesthetising children. The goal was to create an easily accessible, succinct and relevant resource.

Method: Trainees across the region were invited via social media to participate in identifying topics: vascular access, pain management, and a quick reference resuscitation guide were selected for development and dissemination across the South West. With local consultant oversight we utilised paediatric clinical leads, trainee channels and social media to disseminate the resources. Social media responses are analysed and a survey then conducted across the region via email and WhatsApp.

Results: The infographics were viewed over 1,000 times and resulted in a increased presence of South West Association of Children's Anaesthetists on social media. The survey had 21 respondents - most clinicians surveyed were not aware of the resource. However, 100% of those who were aware had used them in their clinical practice. The most accessed resource was the pain infographic. 70% of users found them useful or very useful and 81% would like more topics to be added.

Conclusion: The infographics we developed were well received by those that were aware of them. Accessibility and awareness have not met the aims however. Future work is aiming to improve accessibility, expand on these topics and determine the impact of this intervention.

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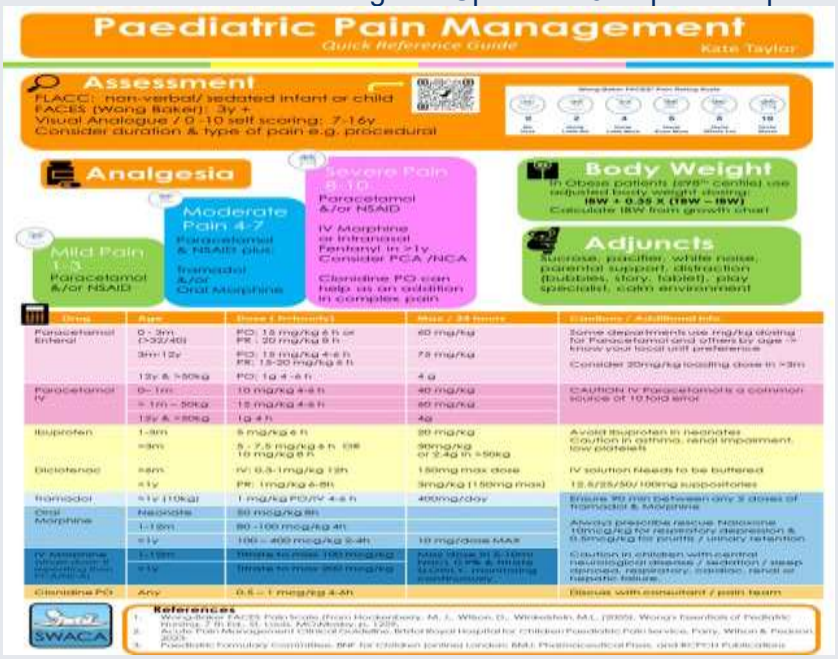

Poster Presentations

21. From Tea Trolley to Entrustment: A Targeted- Teaching Intervention to Support Local Completion of HALOs

Becky Woolf (ST5), Tom Baumer (ST6), Mark Gosling (ST6), Tim Cominos (Consultant anaesthetist), Peter Steed (Consultant anaesthetist) Royal United Hospital, Bath

Introduction: The Royal College of Anaesthetists (RCOA) 2021 curriculum introduced High-Level Outcomes (HALOs) and Entrustable Professional Activities (EPAs), shifting assessment towards capability-based progression. This curriculum change requires residents and trainers to understand entrustment scales for successful sign-off and training progression. Early feedback at the Royal United Hospital (RUH) suggested uncertainty regarding how to utilise entrustment levels and where guidance and resources were located. We designed individualised 'Curriculum Guides' for each clinical domain, for stages 1-3 of training. The documents focused on locally available learning opportunities to fulfil key capabilities for HALO sign off, mapping these to the 2021 RCOA curriculum.

Methods: We delivered tea-trolley teaching sessions within clinical areas. Sessions focused on: (1) locating local HALO sign-off guidance; (2) clarifying entrustment levels within the 2021 Curriculum; and (3) identifying required CCC forms. An anonymous pre- and post-session survey assessed self-rated understanding (using a 10-point Likert scale) and knowledge of guidance location.

Results: Eighteen responses were analysed: 7 residents/fellows and 11 consultants/SAS doctors. Prior to teaching, 4/18 (22%) reported knowing where to find local HALO guidance. Following teaching this improved to 17/18 (94%). Mean, self-rated understanding of entrustment levels increased from 5.6/10 pre-session to 9.7/10 post-session (mean improvement +4.1 points). Awareness of required CCC documentation also improved across all grades. Improvements were observed in both resident/fellow and consultant/SAS groups.

Conclusion: Short, opportunistic tea-trolley teaching was associated with substantial improvement in awareness of local HALO guidance and understanding of entrustment levels. This low-cost, workplace-based educational intervention appears effective for disseminating curriculum changes to mixed seniority groups. Embedding similar micro-teaching strategies may support ongoing implementation of the RCOA 2021 curriculum and enhance trainer–trainee alignment regarding entrustment decisions.

References :

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Poster Presentations

22. Evaluating Combined Effect of Metformin & HK2 Inhibition Therapy on the Metabolic Inhibition of Meningioma Growth

Shashwat Deep, Leandro Jose De Assis

Introduction: Meningiomas are the most common benign intracranial tumours, graded I–III, with grade III associated with less than 60% five-year survival. Hexokinase II (HKII), a key glycolytic enzyme, is upregulated in higher-grade meningiomas and promotes increased glucose utilisation. Metformin, a mitochondrial complex I inhibitor widely used in type 2 diabetes, has been associated with reduced incidence of benign brain tumours in cohort studies. This study investigated whether HKII knockdown enhances metformin sensitivity in meningioma cell lines as a potential metabolic therapeutic strategy.

Methods: Immortalised GFP-expressing meningioma cell lines were cultured in 96-well plates and divided into HKII-normal and HKII-knockdown groups. Cells were treated with increasing concentrations of metformin, and GFP fluorescence was measured every 24 hours for 72 hours to generate growth curves and determine IC50 values. Cell viability following treatment was assessed using an MTT assay. Each condition included three biological replicates with four technical replicates.

Results: Across three evaluable cell lines, HKII knockdown resulted in higher IC50 values for metformin, indicating reduced drug sensitivity compared to HKII-normal cells. CH157 and KT21 demonstrated increased resistance following HKII suppression, suggesting possible metabolic compensation and enhanced mitochondrial reliance. NCH93 showed no significant difference in response. BM1 data were insufficient to determine IC50 accurately and require repetition with extended dosing ranges.

Conclusions: These findings suggest that HKII suppression alone does not potentiate metformin cytotoxicity and may induce metabolic adaptation in certain meningioma subtypes. From a neuroanaesthetic perspective, tumour metabolic profiling may influence perioperative metabolic management strategies. While this study does not demonstrate tumour size reduction, understanding metabolic plasticity in meningioma cells may inform future adjunctive metabolic therapies aimed at improving surgical and anaesthetic outcomes. Further in vivo studies are required to clarify translational relevance

Poster Presentations

23. Supporting Diverse Routes into Medicine Design and Evaluation of a Student-Led Educational Website

Shashwat Deep, Finley Black, Annette Serrao, Michelle Lau, Ifeoluwa Aboyewa, Kara Anderson, Hannah Hegarty, Kavin Kandeepan, Medical students, Plymouth medical school, Plymouth

Introduction: Medicine attracts individuals from diverse backgrounds, cultures, and life experiences, and no two journeys into the profession are identical. Applying to medical school can be a daunting process due to the wide range of entry routes and complex requirements at each stage. Many applicants are encouraged to plan early, particularly those applying directly after A-Levels, where work experience and academic preparation are emphasised. However, this project aimed to highlight alternative pathways into medicine, including applying as a mature student through the GAMSAT and transferring from biomedical sciences to medicine, which are available at certain UK universities.

Methods: An online resource was developed using Wix to present clear, structured guidance on the medical school application process across multiple pathways. The website combined practical information with personal experiences, highlighting key attributes associated with successful applicants such as resilience, sustained motivation, conviction, and consistency. The resource was presented at three schools, after which students were invited to complete a survey evaluating usability, relevance, and perceived usefulness. Students were able to independently explore sections most relevant to their individual stage and interests.

Results: Most participants (90.9%) reported that the website was easy to navigate, and 81.8% felt they had learned something new, suggesting the resource was informative and relevant. A small proportion of participants (3%) reported usability issues, particularly when accessing the website on mobile devices. Feedback also highlighted areas for improvement, including text readability, colour contrast, and reducing overly dense paragraphs.

Conclusions: Overall, the resource was received positively, with participants finding it beneficial and informative. While improvements to website layout, colour scheme, and content structure were identified, the findings suggest that this student-led resource has the potential to support prospective medical applicants. Regular updates will be required to ensure the information remains accurate and relevant as medical school application processes evolve.

References:

https://daeproject2023grou.wixsite.com/dae-project

Poster Presentations

24. A Novel Method for Providing Education for Conference Delegates: A Pilot Study of Tea-Trolley Training

Dr Nicola S Crowther, ST6 Anaesthetics; Dr Claire Abeysekera, ST7 Anaesthetics; Dr Susan Tetlow, ST6 Anaesthetics; Dr Thea Morgan, ST4 Anaesthetics; Dr Lauren Brain, CT3 Anaesthetics; Department of Anaesthesia and Intensive Care Medicine, Royal United Hospitals Bath NHS Foundation Trust, Bath

Introduction: Tea-trolley training started as a way of providing bite-sized training for the theatre team in their workplace: while the anaesthetist is given a tea break they receive education on a given topic [1]. Recognising that development of new guidelines can be superfluous unless widely distributed to the relevant audiences, we piloted tea-trolley training at the Association's Annual Congress 2024 and the Resident Doctors Conference 2025 to raise awareness of unrecognised oesophageal intubation (UOI) and the PUMA (Project for Universal Management of Airways) guidelines [2,3].

Method: This pilot was the first time that tea-trolley training was used at a conference. We highlighted the risk of UOI and promoted the recently published guidelines [3]. We set up a mobile trolley in the conference's refreshments are, including educational material and cakes, and talked to delegates during breaks [Fig. 1]. We discussed UOI, the human factors contributing to this and strategies to reduce the risk of occurrence. We tailored the teaching to the grade and previous experience of the delegate.

Results: We spoke to >150 delegates at Annual Congress, and >75 delegates at the Resident Doctors Conference. The concept clearly resonated with delegates and was particularly well received by resident doctors. Formal feedback was collected by the conference organisers: 98% [69/70] of respondents rated the teaching as extremely/moderately effective, and 98% [71/72] reported being extremely/moderately likely to recommend this teaching style for future conferences.

Discussion: Advantages of this method at a conference are its non-threatening nature, the ability to adjust it according to the delegate's previous experience and the opportunity for one-to-one or small group discussions. Some of the challenges included the competing priorities during brief break periods and high noise levels in busy communal areas. In summary, our pilot study suggests that tea-trolley training at conferences is a valuable tool for disseminating important updates in clinical guidelines and practice.

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Figure 1: Tea-trolley training

Poster Presentations

25. Quality improvement Project Aiming to Reduce Iatrogenic Anaemia in Gloucestershire Royal Hospital NHS Intensive Care Unit

Dr William Everden (CT2 anaesthetics) & Dr Rosie Hughes (CT3 anaesthetics), Dr Sophie Scutt (consultant anaesthetist), Laxmi Chapagain (transfusion practitioner), Dr Simon Webster (intensive care consultant)

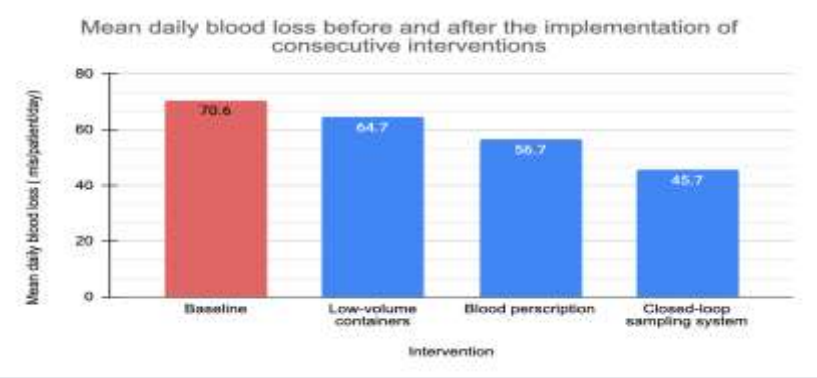
Background: Anaemia is an established risk to critically ill patients. 95% of patients are anaemic by day 7 of intensive care (ICU) admission (1). Iatrogenic blood loss is a known contributor to anaemia. Critically ill patients suffer reduced erythropoiesis from whom phlebotomy removes 40-90mL of blood/day (2). Anaemic ICU patients suffer worse outcomes (3). Reducing iatrogenic blood loss represents a key target for improving outcomes.
Objective: To audit iatrogenic blood loss in Gloucestershire Royal Hospital (GRH) ICU and test sequential interventions to reduce these volumes.
Method: We retrospectively recorded all diagnostic blood draws in adult ICU patients over a 96-day period. Blood loss/patient/day and sample type were measured.
Three intervention cycles were tested:

1. Introducing low-volume sample bottles.
2. Improving clinical practice regarding frequency of ABGs and sample collection
3. Closed-loop ABG sampling system

Results: Initial audit demonstrated mean iatrogenic blood losses of 70.6 mL/patient/day.
Consecutive interventions reduced daily blood loss totals in mL/patient/day (% reduction from baseline):

1. Low-volume bottles: 64.7 mL/patient/day (8.4%).
2. Daily blood sampling prescription protocol: 56.7 mL/patient/day (19.7%)
3. Closed-loop ABG sampling system: 45.7 mL/patient/day (35.3%) - Implementation pending business case approval.

After implementing all 3 interventions, iatrogenic blood losses reduced to 30.8 mL/patient/day (56.4%).
Total blood saving was 279 mL/patient/week.



Conclusion: Our audit demonstrated iatrogenic losses in GRH ICU of 70.6mL/patient/day - significant enough to cause anaemia and worsen outcomes. Our simple, reproducible cost-effective initiatives achieved a 56.4% reduction in iatrogenic blood loss saving almost a unit/patient/week. We show targeted intervention of equipment and clinical practice reduces iatrogenic volumes; and thus advocate wider adoption of such strategies. Future work will evaluate ongoing compliance, transfusion rates and clinical outcomes.

References

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Poster Presentations

26. The Elephant in the Room: Education surrounding the National Emergency Laparotomy Audit (NELA)

Dr Danielle Hill, Dr Andrew Parrish, Dr Elizabeth Hope, Dr Shyam Moudhgalya, Dr Rob Palin

Introduction: The National Emergency Laparotomy Audit (NELA) was designed to ensure compliance with evidence-based standards for emergency general surgery (1). Our trust identified a need for improved awareness after multiple eligible cases were not uploaded to the NELA database, resulting in inaccurate summary data. This prompted a collaborative response to strengthen audit processes and ensure a more accurate reflection of patient care.

NELA Champions were appointed, and an initial survey of 26 anaesthetists revealed key gaps: although 77% felt confident they understood NELA, 42.3% were not confident about their responsibilities for data entry, and 27% were unaware that the NELA audit is separate from the risk calculation score. When asked to identify cases to include from 5 examples, only 50.4% answered correctly, despite 80.7% reporting confidence in using the inclusion/exclusion criteria.

Methods: We implemented an educational strategy centred around a recognisable "Think NELA" logo (Figure 1). Interventions included lunchtime teaching, posters, a flow-diagram of inclusion/exclusion criteria, and a comprehensive NELA guidebook. The logo was placed on computers and emergency theatre areas to act as a visual prompt.
We also delivered a tea-trolley teaching session featuring trust-level NELA data and interactive games on mortality rates and case inclusion. A repeat survey was then disseminated.

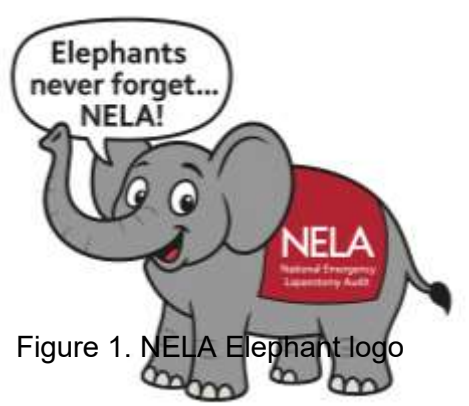

Figure 1. NELA Elephant logo

Results: 40% of clinicians surveyed reported improved understanding and access, and half found the inclusion/exclusion posters very helpful. Correct case identification improved in four of the five scenarios by an average of 10%, though 70% still felt they needed further support. Overall education was rated 4.2/5, with positive feedback highlighting the tea-trolley and flow-chart resources.
Discussion: A combined approach headed by our logo ensured staff were reminded about the audit and encouraged multi-disciplinary collaboration to improve Trust outcomes. Future interventions will now focus on staff engagement, further tea-trolley teaching and maintaining brand visibility to further improve performance.

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Poster Presentations

27. On the Right Trache: A Five-Year Review of the Severn ACCS Tracheostomy Course

Peter Sykes[1], Enyioma Anomelechi[2], Peter Clements[2], Sam Rogers[3], Duncan Castle[1], Henry Munby[1], Tamsin Lane[4] & Dominic Janssen[5]

1. Bristol Royal Infirmary, University Hospitals Bristol and Weston NHS Foundation Trust
2. Gloucester Royal Hospital, Gloucestershire Hospitals NHS Foundation Trust
3. Royal United Hospital, Royal United Hospitals Bath NHS Foundation Trust
4. Great Western Hospital, Great Western Hospitals NHS Foundation Trust
5. Southmead Hospital, North Bristol NHS Trust

Introduction: Tracheostomies pose a significant challenge for resident doctors, particularly at core training level. Although their insertion is common, tracheostomy-related incidents account for approximately half of airway-related deaths in critical care.[1.2] Furthermore, many NHS trusts roster core residents on intensive care and anaesthetic on-call rotas wherein emergency tracheostomy management may prove vital. Despite this, formal teaching remains limited.[2] The Severn ACCS Tracheostomy Course was created in October 2020 to address this gap. This review evaluates the course's development over five years.

Methods: A one-day teaching programme was developed with a focus on emergency algorithms produced by the National Tracheostomy Safety Project.[3] All teaching materials were approved by two local intensive care consultants. A variety of teaching modalities have been utilised including lecture-based presentations, small-group workshops and simulation scenarios. The course is advertised to all ACCS and core anaesthetic residents in the Severn Deanery. It runs biannually and is free to attend. Feedback is gathered after each course and adaptations made accordingly.

Results: The course has run eleven times since October 2020, attended by 198 core residents in total. It is now a formal part of the Severn Anaesthesia teaching programme and remains consistently oversubscribed. Post-course analysis showed 97.1% of residents strongly agreed the course was very relevant to their practice, while 98.5% would highly recommend to colleagues. Prior to the course, 94.1% of residents reported being 'somewhat' or 'not at all' confident managing tracheostomy-related emergencies, falling to 17.6% post-course.

Discussion: The Severn ACCS Tracheostomy Course has addressed a previously underrepresented component of core resident training. Consistent oversubscription, integration into the formal Severn Anaesthesia teaching programme, and positive feedback demonstrate both its educational value and sustained demand. Future development will focus on expansion, as the course structure is readily transferable and could easily be implemented across other deaneries in the UK.

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Poster Presentations

28. Scaling Surgical Skills: Impact of a Cross-Society Suturing Workshop Programme for Medical Students

Smriti Kumar, Khadeeja Nauman, Shashwat Deep, Joshua Munshi

Aim: To evaluate the impact of a structured suturing workshop series delivered through a collaborative, cross-society teaching model on medical students' confidence in basic suturing skills, and to identify curriculum-level deficits in undergraduate surgical training.

Methods: A mixed-methods pre–post educational evaluation was conducted for a suturing workshop programme delivered from January to May 2025. Workshops were held approximately every two weeks across multiple surgical and specialty societies and were open to medical students from universities across the South West and Wales. All attendees were included. Each 1-hour session covered core suturing skills, with optional advanced components. Teaching was delivered by an ST7 obstetrics and gynaecology trainee, surgical registrars and trained student educators. Participants completed identical pre- and post-workshop questionnaires assessing confidence using a 1–5 Likert scale, alongside baseline questions on prior exposure and perceived training gaps. Quantitative data were summarised descriptively with comparison of paired confidence scores. Free-text responses underwent content analysis.

Results: A total of 174 responses were analysed. Baseline confidence was low, with 72% rating themselves 1–2/5. Mean confidence increased from 1.96 to 3.79 (+1.83 points; 94% relative improvement), and the median rose from 2 to 4. High-confidence ratings (4–5/5) increased to 69%, while low-confidence ratings fell to 7.5%. Prior exposure was limited, and 86.9% reported insufficient practical skills teaching. Workshops were highly rated across all measures. Content analysis identified recurring themes including limited formal skills training and restricted access to hands-on opportunities.

Conclusion: Medical students demonstrated low baseline confidence in suturing, and participation in the workshop programme produced substantial improvement. These findings indicate that extracurricular, collaboratively delivered surgical skills teaching can effectively address gaps in undergraduate curricula and may represent a scalable model for early surgical training.

Poster Presentations

29. In-House Paediatric Anaesthesia Simulation Training: a Consultant Update Programme to Support Maintenance of Skills in the Acutely Unwell Child

Gemma Talling[1], Katharine Blyth[2]
[1] ST8 Anaesthesia & Intensive Care, Great Western Hospital, Swindon
[2] Consultant Anaesthetist & Paediatric Anaesthesia Lead, Worcestershire Royal Hospitals

Background: Paediatric emergencies are high-risk but infrequent in many district general hospitals, creating challenges for maintaining consultant competence and confidence. We developed an in-house simulation-based update programme to support skill retention and system familiarity in managing the acutely unwell child.

Methods: A structured consultant update programme was implemented across a cross-site NHS trust delivering peri-operative and level 2/3 critical care services. Content aligned with Resuscitation Council UK guidance and incorporated paediatric basic life support, choking management, and an ABCDE approach based on European Paediatric Advanced Life Support principles. Scenarios were designed and piloted by the authors, with trainee testing to optimise fidelity and cognitive load. Sessions were delivered in situ using existing equipment. Debriefing emphasised human factors, communication, role allocation, escalation to paediatric intensive care and the logistics of preparation for transfer. Pre- and post-session electronic surveys assessed self-reported confidence and familiarity with local systems using Likert-style responses.

Results: Fifty consultant anaesthetists are employed across the trust. The programme aimed to target those covering CEPOD, trauma, ITU plus elective lists with children.
Twenty-five consultants attended completing pre-session surveys. Confidence improved substantially: pre-session, 4% (1/25) reported being “very confident” and 24% (6/25) “not so confident”; post-session, 54% (13/24) were “very confident” and none reported low confidence.
Low confidence in managing and stabilising paediatric emergencies fell from 44% (11/25) to 0%. Knowledge of paediatric emergency equipment location increased from 52% to 100%, and awareness of a drug calculation resource from 76% to 100%. All participants rated the session “very” or “extremely useful,” and 100% would attend annually.

Conclusions: In situ paediatric simulation for consultants was feasible, scalable, and highly valued. Beyond improved confidence, it enhanced system familiarity and reinforced non-technical skills essential for early stabilisation. In low-frequency, high-risk contexts, this model offers a sustainable approach to competency maintenance and patient safety.

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3. Resuscitation Council UK. *Paediatric basic life support and paediatric advanced life support.* London: Resuscitation Council UK; 2021.

Poster Presentations

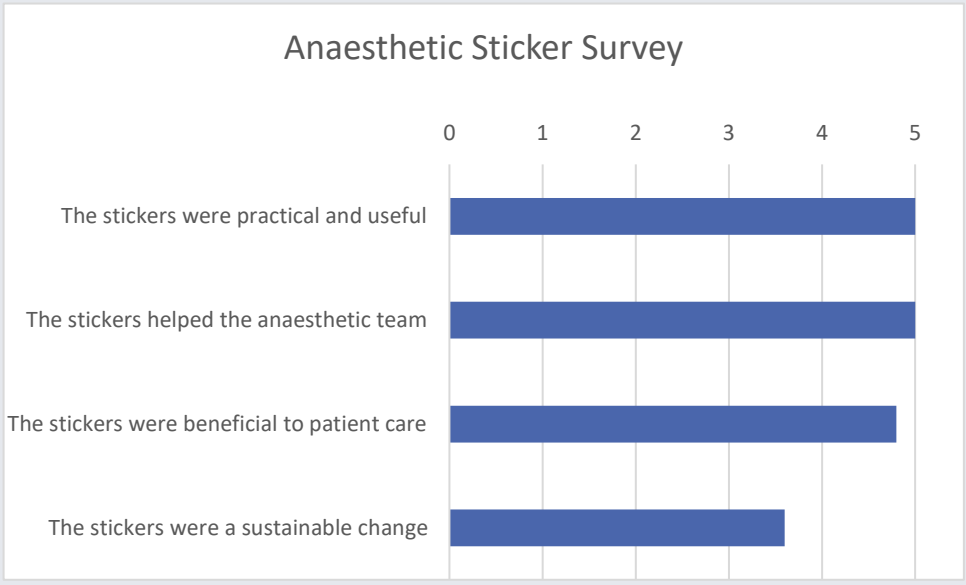
30. Making Stickers Stick

Dr Henry Richardson Banks, North Bristol NHS Trust, Tintswalo Hospital, Tshemba Foundation, NHSE Global Health Volunteer Fellowship

Introduction: Anaesthesia at Tintswalo Hospital in South Africa is performed with limited resources and expertise. During a six-month voluntary placement there I delivered education in anaesthesia. Drug errors on induction were a problem, primarily due to unclear and inconsistent labelling of syringes. Standardised labelling is known to improve anaesthetic safety[1] and I aimed to implement this.

Method: In anticipation of restricted equipment, I took anaesthetic syringe label stickers to South Africa. I introduced these to the local anaesthetic team; we trialled them in theatre and subsequently agreed to continue using them as the local team saw fit. I then collected data, counting any uncorrected mis-labelling I observed or any reports from the team as a drug error. At the end of my placement I performed a qualitative survey to assess the impact of the project.

Results: In three months following the introduction of the stickers I recorded three drug errors compared to two in two weeks beforehand. Due to variation in the number of anaesthetics performed and no standardised reporting format I am unable to show statistical significance. However, the change had a qualitative improvement as demonstrated by the positive feedback from a survey of the local team. (Below).



Discussion: This project demonstrates the benefit of sharing established anaesthetic practice in new environments. Anaesthetic stickers are a success because of their intuitive design; education does not have to be training but instead the introduction of a good idea[2]. The quick uptake and positive qualitative feedback on the stickers supports this. Sustainability concerns were highlighted in that feedback; I introduced a suggested kit list for visiting anaesthetists to include stickers. With a current average of 1-2 volunteers a year I hope this will be a lasting educational change.

References:
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Poster Presentations

31. Simulation Teaching and Technology Enhanced Learning (TEL) for the Multidisciplinary Team (MDT) in the Anaesthetic Department

Dr Janice Neo[1], Dr Paul Holgate[1], Dr Mohamed Elriedy[1], Dr Laura Carrick[1]
[1]University Hospitals of Derby and Burton (UHDB)

Introduction: Access to quality anaesthetic education is increasingly constrained by clinical pressures and workforce limitations. Reduced exposure to critical incidents limits opportunities to develop both technical and non-technical skills. Simulation based education provides a safe, controlled environment for repeated practice. Technology enhanced learning (TEL) can improve accessibility despite rota and location challenges. We describe a multi-modal simulation and TEL programme designed to enhance anaesthetic training across the multidisciplinary team (MDT).

Methods: Anaesthetic doctors, ODPs and recovery nurses identified priority areas including anaesthetic critical incidents, difficult airway management and application of clinical algorithms. Learners were stratified by experience and targeted programmes were developed.
A simulation programme for novice anaesthetic trainees comprised five full day sessions over four months, aligned with the RCoA curriculum and incorporating human factors and crisis management.
A “tea-trolley” teaching initiative delivered brief, opportunistic simulation sessions to anaesthetic doctors, ODPs and recovery staff within theatres. Pre and post session feedback assessed relevance and self-reported confidence.
In collaboration with ExR, immersive 360° videos demonstrating management of critical incidents were developed as repeatable remote learning resources to complement in-person teaching.

Results: Over 12 months, three cohorts completed the novice programme and six tea-trolley sessions were delivered over 9 months. For tea-trolley sessions, 100% of participants reported relevance and appropriate level. Pre-session, 56% reported low confidence managing scenarios and post-session, 87% reported high confidence. Within the novice programme 100% rated scenarios as relevant and high quality. 75% reported improved situational awareness, communication and decision making. Attendance across programmes was limited by rota pressures and clinical demand.

Conclusion: Simulation is highly valued but resource intensive and difficult to sustain consistently. The tea-trolley model enabled flexible, in-situ MDT education without protected time. Integration of immersive TEL resources aims to improve accessibility, consistency and sustainability of training. This supports development of essential skills while enhancing patient safety.

References:

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Poster Presentations

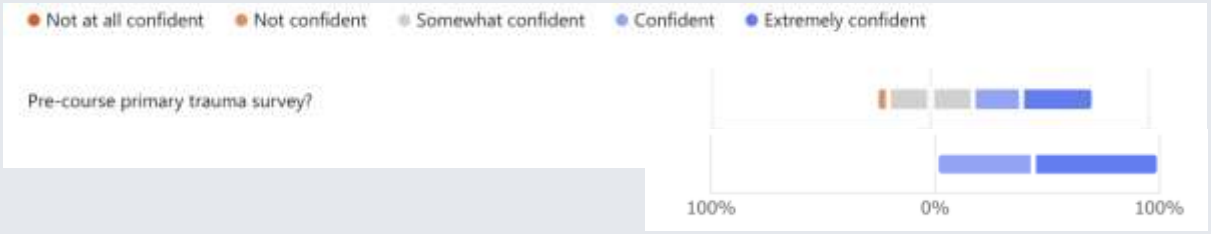
32. Development of an In-Hospital Trauma Management Course for Final Year Medical Students

Dr Leo Moulder CT3, Dr Mohan Ranganathan Consultant Anaesthetist (South Warwickshire NHS Foundation Trust)

Introduction: Trauma teaching for medical students was previously often underrepresented in medical school curricula. In a survey of final year medical students only 60% had trauma teaching of up to 5 hours in total.[1] A more recent scoping review revealed trauma teaching is becoming more prevalent with consequent increases in student confidence, albeit with median course length of 3.5 hours.[2] This full day simulation-based course delivered by members of the Anaesthetic Department was developed to allow 21 final year medical students to gain experience in managing patients presenting with trauma within the hospital environment.

Methods: Pre-course materials including a set of MCQs were sent out to the students prior to the course. The day involved a series of lectures on trauma care and human factors prior to small group-based teaching trauma management skills utilised within the A-E structure of the primary survey. Simulated management of common trauma pathology was practiced following a faculty led demonstrative simulation. Pre and post course surveys were taken to gauge effectiveness of teaching.

Results: Results show that the course improved confidence of the students with mean self-rated scores on knowledge of trauma care increasing from 3.72 to 4.56 across the cohort. The below graph demonstrates the improvement in confidence of students performing a primary survey pre and post course, with most being extremely confident post course.



Discussion: The course was shown to be an effective tool for increasing confidence in students undertaking the primary survey and managing some common traumatic pathology. Other benefits included an increase in students' self-reported confidence in handling high pressure situations and working as part of a clinical team. Feedback received suggested pre-course material could include more information on catastrophic haemorrhage and C-spine manipulation to improve confidence, this will be incorporated for future sessions.

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Poster Presentations

33. Bridging the Gap: Simulation-Based Training Strategies for Ultrasound-Guided Neuraxial Anaesthesia: An Educational Scoping Review

Mahfouz Sharapi[1], Louise Crowley[2], Helena McKeague[2] [1]Post-CCT Paediatric Anaesthesia Fellow, LGI, Leeds, UK. [2]Health Professions Education Unit, School of Allied Health, University of Limerick, Limerick, Ireland.

Introduction: Ultrasound-guided neuraxial anaesthesia (UGNA) improves procedural accuracy, first-pass success, and patient safety, but requires complex cognitive and psychomotor skill acquisition. Simulation-based training (SBT) is increasingly used to support UGNA education; however, the range of available simulation tools, their educational effectiveness, and barriers to implementation remain poorly synthesized. This scoping review aimed to map SBT modalities used for UGNA, evaluate educational outcomes, and identify implementation challenges relevant to anaesthesia training.

Methods: A scoping review was conducted in accordance with PRISMA-ScR guidance. PubMed, Embase, Web of Science, Scopus, and CINAHL were searched from database inception to March 2025. Studies evaluating simulation-based educational interventions for UGNA were included. Two reviewers independently screened titles, abstracts, and full texts, with data extracted using a predefined charting framework. Educational outcomes were categorized using the Kirkpatrick evaluation model.

Results: Sixteen studies met inclusion criteria, including randomised controlled trials, feasibility reports, and pre–post or observational studies. Simulation modalities included low-cost gelatine and 3D-printed phantoms, augmented and virtual reality platforms, hybrid systems incorporating needle tracking, and web-based learning modules. All studies reported improvements in technical skills, including needle trajectory accuracy and sonoanatomy recognition, and learner confidence, predominantly at Kirkpatrick Levels 2b and 3. Outcome assessment was largely short-term; only two studies evaluated skill retention beyond one week, with one reporting sustained effects at three months. No studies assessed patient-level outcomes.

Discussion and Conclusion: SBT enhances short-term technical performance and confidence in UGNA learners. However, the evidence base is limited by methodological heterogeneity, limited longitudinal assessment, and absence of patient-level outcomes. Common barriers include high simulator costs, limited faculty expertise, lack of standardised assessment tools, durability issues with physical phantoms, and time constraints in clinical training environments. Future research should prioritize longitudinal skill retention, faculty development, validated competency assessment, and scalable, cost-effective simulation frameworks across undergraduate and postgraduate anaesthesia training programmes.

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Poster Presentations

34. The Gas Exchange Network – A Regional, Peer-Led Educational Programme Pilot

A Chandrasekar, A Butler, E Brown, S Calmonson, NorthWest School of Anaesthesia, Wythenshawe Hospital, Stepping hill Hospital, North Manchester General Hospital

Introduction: The Primary FRCA examination represents a pivotal milestone for UK anaesthetic trainees, often demanding extensive self-directed study. Peer-led teaching offers a potentially powerful strategy, enhancing trainee confidence, exam preparedness, and engagement[1], while also developing teaching skills among tutors and reducing faculty burden[2]. The shift to virtual platforms has further increased accessibility, especially across geographically dispersed deaneries.

Methods: A free, regional, peer-led programme for Stage 1 trainees was piloted in the Northwest School of Anaesthesia. 24 virtual sessions were delivered weekly over 2 cycles and designed to maximise engagement through interactive small-group discussions, real-time knowledge testing utilising Slido© and mock OSCEs to simulate exam conditions. A collaborative network was created to empower trainees to organise peer-to-peer study and share resources. Feedback was systematically collected after each session and upon programme completion.

Results: Forty candidates registered for the programme. Analysis of 129 session feedback forms revealed candidates' median confidence on session content increased from 3/5 (IQR 1) prior to teaching to 4/5 (IQR 0) afterwards. Subjective preparedness following teaching was high (median 5/5 (IQR 1), and overall session ratings were consistently excellent (median 5/5 (IQR 0).

Among 24 end-of-programme respondents, 87.5% rated the programme 5/5, 83.3% rated the structure as excellent, and 100% found topics highly relevant. Significant improvement in understanding was reported by 79.2%, confidence increased in 95.8%, while 83.3% felt self-directed revision burden was reduced (significant/moderate). 66.7% strongly agreed the programme helped identify knowledge gaps and 100% would recommend the programme to colleagues.

Conclusion: This peer-led programme demonstrably empowered anaesthetic trainees by enhancing confidence, preparedness and understanding for the Primary FRCA. Participants consistently reported reduced revision burden and a strong sense of support within a collaborative learning environment. The positive feedback underscores the programme's effectiveness in not only preparing trainees for assessment, but also in fostering development of future educators within anaesthesia.

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Disclaimer: As this programme was not conducted for formal research purposes, the findings should not be interpreted as research outcomes. None of the authors have any affiliation with the online platform, Slido©.

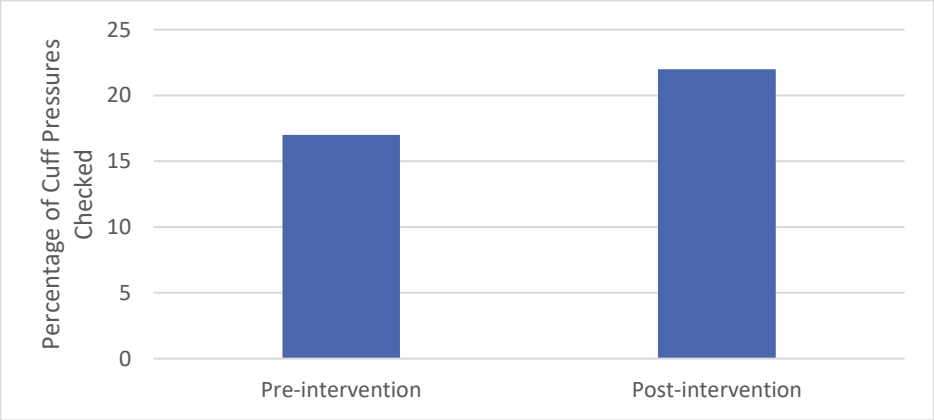
Poster Presentations

35. Improving Cuff Pressure Monitoring using a Peer-to-Peer Approach

Dr Ben Jones ST7[1], Dr Ancy John ST7[1], Dr Lisa Wee Consultant[1], Gemma Allen Operating Department Practitioner[1]. [1] Manchester Foundation Trust

Introduction: Raised tracheal and tracheostomy cuff pressures were identified as an area of concern by local audit and clinically high pressures can cause serious clinical sequelae like tracheal necrosis [1]. Creating clinical change in an NHS under huge resource pressures represents a challenge. Innovative ways of teaching without sacrificing clinical efficiency or increasing costs represent an appealing concept. We collaboratively designed a brief presentation and handout alongside one of our operating department practitioners (ODP) highlighting the importance of monitoring cuff pressures. This was delivered by an ODP to other anaesthetic practitioners during a normal working day after which additional manometers were introduced into practice.

Methods: Teaching was delivered to anaesthetic practitioners in the form of mobile "tea-trolley teaching" within a normal working day. We utilised our trusts electronic notes system to identify intubations and tracheostomies performed in the 3 months pre and post intervention and the frequency with which cuff pressure was recorded.



Results:
Figure 1: Graph showing the percentage of endotracheal and tracheostomy cuff pressures checked in the 3 months before the "tea-trolley teaching" and the 3 months post-intervention.

Results: As shown in Figure 1 our interventions achieved a 29% increase in the monitoring of tracheal cuff pressures within our hospital in the 3 months post-intervention.

Discussion: In this study we have showed that working collaboratively with allied health professionals (in this case an ODP) to assist and empower them to deliver peer-to-peer teaching can result in improved clinical care without the need to sacrifice clinical efficiency or incur financial cost. We focused on a peer-to-peer model as previous studies highlighted that peer-to-peer teachers have greater understanding of the role and pressures of those they are educating although they do require more support when delivering teaching [2]. The ODP involved in our study highlighted an increased confidence in delivering the teaching thanks to our support. We feel this intervention is easily reproducible and could be utilised to educate staff in a vast range of clinical issues.

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Poster Presentations

36. The Bristol Clamshell Resuscitative Thoracotomy Course: Establishing a Multi-Disciplinary Multimodal Learning Resuscitative Thoracotomy Course

J Dryburgh-Jones[1], J Pasztorova[2], E Low[3], S Gaitanakis [4], S Mohamed[5]
[1] CT3 Anaesthetist GHNHSFT, [2] ICM Junior Clinical Fellow NBT, [3] ST6 Anaesthetist UHBW, [4] Consultant Thoracic Surgeon UHBW, [5] Consultant Cardiac Surgeon and Supervising Consultant USH

Introduction: Recent experience within trauma units in the Severn Major Trauma Network has highlighted that effective care during resuscitative thoracotomy (RT) depends on the multidisciplinary team sharing a mental model of how and when to perform this procedure, understanding the human factors influencing team performance, and preparing the patient for theatre or transfer. Anaesthetic trainees are a key part of this team, as these cases often occur out-of-hours. Despite national guidance highlighting its importance[1], no regional multidisciplinary course existed to address this training need. The Bristol Clamshell Resuscitative Thoracotomy Course was therefore created, aiming to establish a shared mental model among healthcare professionals across the South West, so that ad hoc teams responding to these patients can follow a standardised management approach with confidence.

Methods: The course uses multimodal learning, including a manuscript and pre-course videos. Faculty, including cardiothoracic surgeons, teach technical skills at workstations using mannequins and a wet lab with medical-grade porcine mediastina. A structured team approach to RT is developed using eight moulages, four based on recent regional cases. These simulations focus on developing non-technical skills such as leadership, crisis resource management, and teamwork, alongside the decision-making processes required to proceed to RT. Each moulage is observed by other candidates, who are assigned themes to note, forming the basis of a debriefing conversation facilitated by faculty using the diamond model[2]. The faculty comprises anaesthetists, surgeons, emergency physicians, and nursing staff.

Results: Pre- and post-course surveys (Fig. 1) demonstrate that our blended learning approach significantly increases candidate confidence in both the technical and non-technical skills required to manage traumatic chest injury.

Discussion: Our experience demonstrates that simulation-based training with a multidisciplinary group reflecting real-life clinical teams enables the development of a shared mental model and increased confidence among learners. This approach to training may be useful in other high-acuity, low-occurrence anaesthetic emergencies.

"From 1 (poor) to 5 (excellent), how would you rate your confidence in your…"	Pre-Course	Post-Course	Percentage change
Ability to perform a clamshell thoracotomy	1.85	4.35	+135%
Ability to team lead during chest trauma	2.38	4.16	+75%
Ability to act as a resource co-ordinator	2.26	4.32	+91%
Ability to work as a team to expedite the time-critical transfer of an unstable patient	3.25	4.41	+36%
Ability to work collaboratively to facilitate a thoracotomy	2.79	4.58	+64%
Knowledge of existing guidance for chest wall trauma	2.62	4.47	+71%

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Poster Presentations

37. Ultrasound Probe Decontamination for Single Shot Peripheral Nerve Blocks

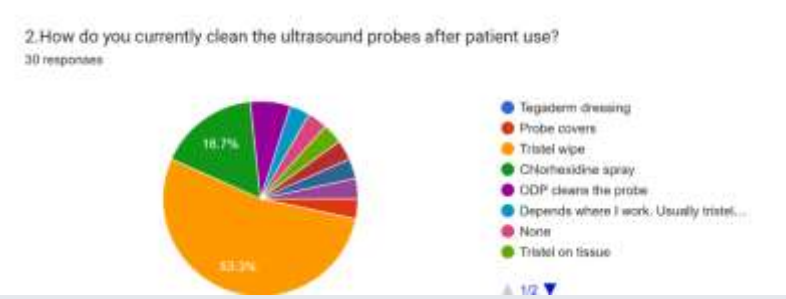
Sindhu Sapru, Arunita Jha, Laith Malhas, University Hospitals Coventry and Warwickshire

Introduction: Ultrasound guidance is integral to regional anaesthesia practice. Although probes used for single-shot peripheral nerve blocks are classified as non-critical devices, their use adjacent to sterile procedures necessitates effective decontamination, however, variation in implementation may pose patient safety and governance concerns.

Aim: To evaluate current ultrasound probes decontamination practices between single shot peripheral nerve blocks and assess awareness of relevant guidance.

Method: A single-centre, cross-sectional online survey was conducted amongst anaesthetic consultants, operating department practitioners, and anaesthetic associates. The survey assessed probe cleaning methods, disinfectant choice, use of probe covers, and awareness of existing guidance. This project was undertaken as a service evaluation.

Results: Survey responses demonstrated marked heterogeneity in practice. Variability was observed in the method and timing of probe decontamination disinfectant products used, and reliance on sterile probe covers. No agreed local standard or consistent interpretation of guidance was identified.



53.3% felt probe covers are unnecessary for single shot nerve blocks - 56.7% felt ultrasound probe requires low level of disinfection (LLD)

Discussion: Despite extremely low reported infection rates following ultrasound-guided single-injection peripheral nerve blocks, variation in practice represents a governance variation concern.
Rare infection outbreaks, including those related to contaminated multi-use ultrasound gel, highlight system-level risks. Inconsistent decontamination practices increase the potential for lapses in infection control. Additionally, the use of improvised probe barriers may raise manufacturer warranty concerns, while the use of sterile covers without fully sterile setup lacks supporting evidence and carries cost and environmental implications.

Conclusion: Clear, standardised local guidance supporting appropriate LLD and adherence to manufacturer recommendations is required to promote consistent, safe, and defensible regional anaesthesia practice, with clear educational value for trainees and departments.

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2.Cost of sterility: probe covers should not be mandated for single-shot peripheral nerve blocks
Philipp Gerner , Veena Graff, ,Melody Herman ,Alexander B Stone
Reg anaesth pain med: 22 May 2024
3. Infection related to ultrasound-guided single-injection peripheral nerve blockade: a decade of experience at Toronto Western hospital regional anaesth pain med: 2015 Jan-Feb;40(1):82-4.Husni Alakkad 1, Amir Naeeni, Vincent W S Chan, Sherif Abbas, Justin Oh, Noam Ami, Jessica Ng, Michael Gardam, Richard Brull

Poster Presentations

38. Knowledge Donation: A simulation based educational intervention

Dr Edward Cook – CT4 ACCS Anaesthetics, Salford Royal
Dr James Gorham – ST8 Anaesthetics and Intensive Care, QE
Dr Prabhjoyt Kler – Consultant in Critical Care and Anaesthesia, UHNM
Dr Neil Davé – ST6 Anaesthetics, UHNM

Introduction: Anaesthetists play a central role in organ donation and retrieval procedures, yet structured teaching within anaesthetic training programmes is inconsistent. Trainees are frequently expected to support donation cases in theatre despite limited formal education. This study aimed to assess baseline knowledge and confidence among trainees and evaluate the impact of a targeted teaching programme.

Methods: A mixed-methods educational evaluation was conducted at a UK teaching hospital. Baseline questionnaires assessed prior exposure to organ donation, self-rated confidence across key domains using a five-point Likert scale, and perceived preparedness for involvement in organ donation cases. A multidisciplinary study day incorporating didactic teaching and simulation was delivered. Post-course questionnaires repeated confidence measures and gathered qualitative feedback. Descriptive analysis was performed.

Results: Twenty-four anaesthetic trainees completed the baseline survey. Although 79% had previously been involved in organ donation cases, 62.5% were unaware of recent changes to neurological death testing criteria. Baseline confidence was moderate across domains, with particularly low confidence in recognising the anaesthetist's role and understanding legal and ethical frameworks.

Twelve participants attended the teaching and simulation day. Pre-course median confidence across domains was 3. Following the intervention, median confidence increased to 4-5 across all domains, including principles of organ donation, DNC and DCD processes, the anaesthetist's role, and legal and ethical frameworks. Preparedness to be involved in organ donation cases improved, with all participants rating themselves confident or very confident post-course. One hundred percent reported that learning expectations were met and that they would recommend the course. Qualitative feedback highlighted improved role clarity, greater confidence, and the value of simulation in contextualising theory.

Conclusion: Anaesthetic trainees demonstrated significant baseline knowledge gaps despite frequent clinical exposure to organ donation. A focused teaching intervention substantially improved confidence and preparedness, supporting the inclusion of structured organ donation education within anaesthetic training programmes.

References:
National Deceased Organ Donation Course

Poster Presentations

39. Making the Cut; Upholding Educational Standards in Resuscitation-Based Simulation

Authors: Dr. Emma Low,[1] Dr. Jack Dryburgh Jones,[2] Julia Pasztorova,[3] Mr. Stylianos Gaitanakis[4]
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2. Anaesthetic ACCS Doctor, Gloucestershire Hospitals NHS Foundation Trust.
3. Intensive Care Fellow, North Bristol NHS Trust.
4. Consultant Thoracic Surgeon, University Hospitals NHS Foundation trust.

Introduction: Resuscitation courses are an integral aspect of continuous professional development. Course faculty bring a wealth of clinical expertise but may not have any formal simulation training. The ASPiH Standards (2023) provide educators with clear evidence-based guidance for the design, implementation and evaluation of simulation-based training.[1] We discuss how the ASPiH standards are utilised as a quality assurance framework for the Bristol Clamshell Course; a resuscitative thoracotomy course teaching the technical and non-technical skills relevant to the management of blunt and penetrating chest trauma.[2]

Methods: As a committee, we have considered how the ASPiH standards apply to the course content and delivery. We focus on the ASPIH core values including physical and psychological safety, quality, diversity inclusion, sustainability and excellence.[1] These core values underpin everything we do and align with our wider goals of equipping clinicians with the skills to respond to knife crime related assault.[2]

Results: To uphold the rigorous quality standards recommended by ASPiH, we train new faculty with a one day train the trainers course. This explores the underpinning educational theory, adult learning styles, simulation delivery and structured debriefing techniques. Effective debriefing is an essential element of simulation-based education. We use peer Objective Structured Assessment of Debriefing (OSAD) scoring as a means of continuous quality improvement.[3] Pre and post course faculty meetings provide an opportunity for reflection and forward planning.

Discussion: The Bristol Clamshell course is an example of high-quality simulation-based education in the trauma and resuscitation space. The course has a clear overarching strategy to uphold rigorous educational values and standards. Delivering an educationally sound learning opportunity for candidates to achieve the learning objectives of the course.

Conclusion: The Bristol Clamshell demonstrates how rigorous, nationally approved educational standards for simulation-based practice can be incorporated into short trauma-based simulation courses.

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Poster Presentations

40. Developing Multidisciplinary Simulation Based Learning in a Teaching Hospital

Sara Williams, Simulation Lead & Simulation Team, South Warwickshire NHS Foundation Trust

Introduction: Simulation is a vital tool in Medical Education that enhances learning, practice of technical & non-technical skills as well as confidence in working or leading Teams. This modality allows learners to practice skills in a safe environment without affecting patient safety. This is now incorporated into curriculum for medical students, resident doctors, nursing staff and allied health professionals. We would like to highlight how we have incorporated multi-disciplinary Simulation into our Trust

Methods: We did an initial survey on learners' perception of Simulation. We identified what their learning needs & expectations were. We liaised with the clinical leads and governance teams to identify patient safety incidents. We then designed a multi-disciplinary Simulation scenarios individualised to the clinical area. We divided the hospital to 8 zones and allocated 6 weeks in a year to each zone to deliver the simulation training. We also identified additional sessions for drop in training.

We identified funding to run these sessions via the learning agreement. We ran sessions which included medical students, residents as well as clinical staff from all departments. The sessions were delivered in-situ and in our simulation centre. We liaised with multiple teams, clinical leads, ward managers and sim champions, to ensure the learners were rostered into the sessions thus minimising last minute cancellations. We collected feedback on the sessions.

Discussion: The initial survey helped us to identify the learners' educational requirements more accurately and to tailor the training to the relevant areas. The multi-disciplinary training helped us improve the communication between the learners and was highlighted as a valuable aspect of the sessions. They commented that the sessions improved accessibility between the teams in a clinical setting.

We have collected qualitative feedback but will be looking at quantitative feedback in terms of learners' confidence and learning in the next year. We are currently monitoring patient safety incidents to see if the intervention has reduced errors. The initial review shows a reduction, but we understand that this can be multifactorial. We would like to present this to highlight the development of this project which has made simulation based learning part of the training we deliver to all staff in our Trust. We would welcome the opportunity to discuss the logistics in establishing simulation based learning in the clinical setting.

Poster Presentations

41. Outperformed by an Algorithm? Rethinking Anaesthetic Training in the Age of AI

Dr. Kyle Hallas[1], Dr. Anish Ray[1], Dr. Michael McCooe[1, 2], Prof. Tom Lawton[1, 2]
[1]Bradford Teaching Hospitals NHS Trust [2]Improvement Academy, Bradford Institute for Health Research

Introduction: Discharge summary writing is a routine and time-consuming task undertaken by anaesthetic and intensive care trainees. Trainees often complete summaries under time pressure with limited feedback and perceive this as service provision rather than a learning opportunity, particularly for a skill infrequently performed as a consultant. Large language models (LLMs) can generate structured clinical documentation, raising a key question(1). If AI can produce clearer discharge summaries than trainees, what are the wider implications for learning, supervision, and professional development in anaesthetic training? This study evaluated the quality of LLM-generated versus human-written ICU discharge summaries, examining perceived authorship, accuracy, clarity, succinctness, patient comprehension, relevance, and organisation.

Methodology: Thirty ICU patients admitted to the Bradford Royal Infirmary between April and December 2024 were randomly selected. Summaries of their ICU stay were generated by a resident doctor and an LLM ('Amy'). Five anaesthetic trainee assessors evaluated 60 summaries using a structured questionnaire, and one assessor was interviewed. Quantitative data were analysed using Cumulative Link Mixed Models (CLMM). Qualitative feedback was reviewed to identify recurring themes and illustrative quotes.

Results: LLM-generated summaries received significantly higher ratings in clarity (OR=9.06), patient comprehension (OR=7.12), organisation (OR=3.39), succinctness (OR=2.16), and relevance (OR=1.68), with no significant difference in accuracy (OR=0.81). Authorship identification was equivalent (56% correct). Qualitative feedback praised structure and readability in LLM-generated summaries but noted occasional factual omissions and inconsistent emotional tone.

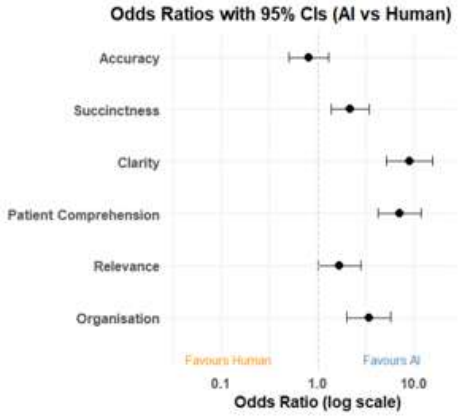

Figure 1: Comparison of Odds Ratios for Quality Domains between AI- and Human-Generated Discharge Summaries.

Conclusions: LLM-generated discharge summaries outperformed human-generated discharge summaries in several patient-centred domains, suggesting routine documentation has scope to be increasingly automated. AI is already entering anaesthetic training through simulated patients and other emerging educational tools(2). As these capabilities expand, automating low-value tasks may create space for higher-yield experiential training(3). The challenge for future anaesthetists will not be keeping up with AI but using that time to become better clinicians.

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Poster Presentations

42. CRISSO: A Resident-Owned Structured Feedback Framework Demonstrating Improvement Across Anaesthetic Training-Environment Domains During a Rotation

Khaled Ahmed (ST6 Anaesthetics), Sarah McAnallen (CT3 Anaesthetics) East Midlands School of Anaesthesia, UK

Introduction: Resident feedback about the learning environment can be variable in quality and difficult to convert into practical change. National benchmarking highlights the importance of supportive training and effective supervision. [1] We developed CRISSO (Claims, Rest & facilities, IT, Sign-off, Support/Supervision, Opportunities) as a resident-owned framework to structure feedback and support educational governance.

Methods: Residents (Foundation to Stage 3) completed anonymised CRISSO surveys one month into the rotation and again at end-of-rotation. They rated six core domains on a 1–5 scale (higher scores more favourable) and could add free-text examples. A parallel College Tutor evaluation explored feasibility and whether CRISSO prompted actions. Participation was voluntary and outputs were reported in aggregate, consistent with the supervision culture described in anaesthetic training guidance. [2] Quantitative results were summarised descriptively, comparing the one-month and end-of-rotation surveys.

Results: The one-month survey received 18 responses; the end-of-rotation survey received 23 responses (Foundation to Stage 3). Median (IQR) ratings improved in four domains: Claims 2 (1–3) to 3 (2.75–4; n=20), Rest & facilities 3 (3–5) to 4 (4–5; n=22), IT 3 (2–4) to 4 (2–4; n=23), and Opportunities 4 (2–5) to 4 (3.5–5; n=23). Sign-off remained stable at 4 (3–5; n=23). Support/Supervision remained high, with an IQR shift from 4 (3–5) to 4 (4–5; n=23). End-of-rotation proportions scoring ≥4/5 were Claims 35.0%, Rest & facilities 81.8%, IT 52.2%, Sign-off 56.5%, Support/Supervision 82.6%, and Opportunities 73.9% (Table 1). The College Tutor strongly agreed CRISSO was feasible and useful, supported continuing the approach, and reported actions arising across several domains; key barriers were competing operational pressures and IT constraints.

Conclusion: CRISSO offered a simple, low-resource way to capture resident-owned feedback in a consistent format and was associated with descriptive improvement across several training-environment domains over a rotation. By providing a clear structure for raising and addressing issues, it may also support openness and psychological safety. [3] CRISSO appears transferable and suitable for wider evaluation across sites.

Table 1. CRISSO domain ratings at one month and end-of-rotation, with end-of-rotation "good/very good" proportions
(Scale 1–5; higher scores more favourable)

CRISSO domain	One-month median (IQR), n=18	End-of-rotation median (IQR)
Claims	2 (1-3)	3 (2.75-4; n=20)
Rest & facilities	3 (3-5)	4 (4-5; n=22)
IT	3 (2-4)	4 (2-4; n=23)
Sign-off	4 (3-5)	4 (3-5; n=23)
Support/Supervision	4 (3-5)	4 (4-5; n=23)
Opportunities	4 (2-5)	4 (3.5-5; n=23)

References:

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Poster Presentations

43. Mocktails and Reflections: A Reflective Practice and Collaborative Learning initiative in Anaesthesia at Northampton General Hospital

A Mehta (Clinical fellow), K Katechia (College tutor & Consultant Anaesthetist), Department of Anaesthesia, Northampton General Hospital

Introduction: Mocktails and Reflections is a Resident-focused reflective practice initiative designed to support collaborative learning within the Department of Anaesthesia at Northampton General Hospital. The project aims to provide a psychologically safe environment in which anaesthesia residents can openly discuss professional challenges and problem-solving strategies encountered in their day-to-day practice.

Method: A series of informal, tutor-facilitated sessions was developed, during which Residents voluntarily presented challenging situations, described troubleshooting approaches and reflected on personal or team-based learning points, all whilst enjoying the ambience of an afternoon mocktail. Attendance numbers, thematic content and subjective Resident feedback were collected across meetings. Qualitative comments were analysed to identify recurrent themes relating to educational value, wellbeing and perceived impact on clinical confidence.

Results: Across the evaluation period, participation remained consistently good, with Residents representing a range of training stages. Common themes included workforce management dilemmas, perioperative decision-making, human factors considerations and approaches to multidisciplinary communication. Residents reported that the informal structure, symbolised by mocktail-based social interaction, encouraged open dialogue and reduced hierarchical barriers. It also encouraged peer-to-peer learning, between locally employed doctors and doctors in training, enhancing working relationships.

Conclusions: Mocktails and Reflections demonstrate that combining informal peer discussion with structured reflective facilitation in a social environment can enhance clinical learning, promote wellbeing, and strengthen team culture within an anaesthesia training department.

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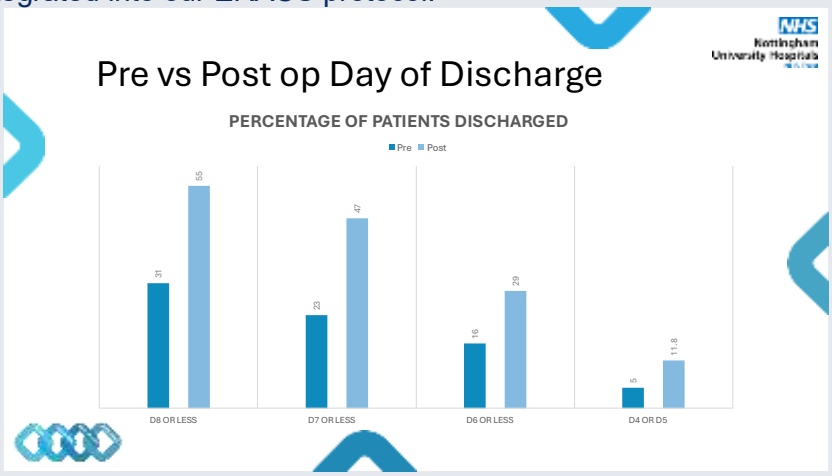
Poster Presentations

44. Development and Implementation of an Enhanced Recovery After Cardiac Surgery (ERACS) Pathway

Melissa Dale, Eleanor Wheeler, Pui Hepplewhite, Jade Dawson, **Gaurav Purwaha**, Prashanth Sadhahalli, Umar Imran Hamid, Julia Glizevskaja, Brooke Morgan, Kunjan Suriakala, Samantha Cartwright, Caroline Orrel, Eleanor Dell, Laura Underhill, Helen Walsh and Beth Savage. Trent Cardiac Centre. Nottingham University Hospitals NHS Trust

Background: Enhanced Recovery After Cardiac Surgery (ERACS) pathway aim to reduce length of stay (LOS) and improve patient outcomes. Cardiac ERACS guidelines were first published in 2019[1]. Within our centre, we implemented a multidisciplinary ERACS pathway with particular focus on peri-operative analgesia and early extubation.

Methods: A six-month retrospective LOS audit was undertaken pre-implementation and compared with a further six-month period after ten months of protocol delivery. To optimise analgesia within the programme, we performed a snapshot audit of 18 consecutive cardiac surgical patients assessing pre, intra and post-operative analgesia. In parallel, a national survey of 12 UK cardiac centres explored current analgesic strategies and protocol standardisation. Findings informed development of a structured multimodal analgesia pathway integrated into our ERACS protocol.



Results: Following ERAS implementation, average LOS reduced from 11.3 to 9.7 days. Discharge by post-operative day (POD) 8 increased from 31% to 55% and discharge on POD 4–5 increased from 5% to 11.8%. Early extubation improved markedly, with mean time to extubation falling from 17–23 hours to 4–8 hours.

Baseline analgesia audit demonstrated no pre-operative analgesia, predominant use of intra-operative fentanyl (17/18 patients; mean 400 µg), intravenous opioid use until POD2, with 6/18 patients receiving oral opioids on POD6. The national survey highlighted limited regional anaesthesia use and variable standardisation across centres.

Intervention: A clear, staged protocol was introduced with induction paracetamol, titrated fentanyl, parasternal/local infiltration (ropivacaine 0.2%, 60 ml), nurse-controlled IV oxycodone in CICU, early transition to short-acting oral opioids post-extubation and cessation of regular opioids by 72 hours where possible.

Conclusion: Implementation of a multidisciplinary ERACS programme was associated with earlier extubation and reduced length of stay. The improvement in extubation likely reflects coordinated MDT engagement and focused adherence to enhanced recovery principles.

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Poster Presentations

45. No stress – Improving Perioperative Steroid Cover in Adrenal Insufficiency

Beth Bowyer NBT

Introduction: Patients on long term steroids for adrenal insufficiency (primary or secondary) or other medical conditions (at prednisolone equivalent ≥5mg/day for ≥4 weeks) are at risk of adrenal crisis during the perioperative period, and require appropriate steroid supplementation. In 2012 a 'Report to Prevent Future Deaths' highlighted concerns about standards of care for patients with adrenal insufficiency undergoing surgery 1 . In response, national peri-operative guidelines on the management of glucocorticoids for patients with adrenal insufficiency were published in 2020 2 , followed by local Trust guidelines in 2023. Our aim was to ensure all patients on steroids received appropriate intra-operative and post-operative supplementation in-line with national and local guidelines.

Methods: Search identified 3,895 patients who had a pre-op assessment in 2024 and had taken steroids within the preceding 12 months. 500 patients were reviewed to identify those taking oral steroids. For patients on oral steroids who met the criteria for steroid supplementation, the anaesthetic chart was reviewed to determine whether intra-operative and post-operative steroid replacement was in-line with guidance. Where no post-operative plan was documented, it was assumed this had not been provided.

Results: Of the 500 patients reviewed, 98 were taking oral steroids and 38 met the criteria for steroid supplementation. Of the 38 patients, 5% had primary adrenal insufficiency, 11% secondary and 84% tertiary. Overall adherence to guidelines was low, with only 63% (24/38) of patients receiving appropriate intra-operative steroid replacement and just32% (12/38) receiving appropriate post-operative steroid replacement. No patients with primary adrenal insufficiency received appropriate intra- or post-operative steroid cover. In secondary adrenal insufficiency, adherence was 50% for intra-operative and 75% for post-operative cover. In tertiary adrenal insufficiency, 69% received appropriate intra-operative cover (most commonly dexamethasone 6.6 mg) but just 28% received appropriate post-operative cover.

Discussion: For PDSA cycle 1, results will be presented at the Anaesthetic Clinical Governance meeting to highlight current guideline adherence and reinforce recommended practice.

Discrepancies between national and local guidelines will be reviewed and aligned. Planned interventions include standardising documentation of post-operative steroid cover (e.g. anaesthetic chart sticker), aligning local and national guidelines, updating the online pre-operative assessment form to specifically identify patients taking oral steroids and repeating the audit to evaluate impact.

Reference:

1. Ministry of Justice. Summary of Reports and Responses under Rule 43 of The Coroners Rules. 20212. Available from https://assets.publishing.service.gov.uk/media/5a7cac35e5274a38e57560cd/summary-rule-43-v7.pdf (accessed 08 January 2026)
2. Woodcock T. Guidelines for the management of glucocorticoids during the peri- operative period for patients with adrenal insufficiency. Anaesthesia 2020: 75(5):654-663

Poster Presentations

46. Improving Handover of Patients Stepped Down from Intensive Care to Ward Teams: A Re-Audit

Ifra Zahoor, Shanmugam Rathinavel, Department Of Anaesthesiology and ITU ,Southern Warwickshire NHS Foundation Trust.

Introduction: Safe handover of patients stepped down from the Intensive Care Unit (ITU) to ward teams is a key patient safety priority. These patients are often complex, with ongoing medical issues, frequent medication changes, and outstanding investigations. Inadequate transfer of information can lead to delays in treatment, medication errors, and compromised continuity of care. A previous audit identified deficiencies in verbal and written handover and incomplete transcription of medications to the Electronic Prescribing and Medicines Administration (EPMA) system. This re-audit aimed to assess the impact of interventions introduced to improve the quality of handover from ITU to ward teams.

Methods: A questionnaire-based survey was conducted among ward-based junior doctors and Advanced Nurse Practitioners who routinely receive patients stepped down from ITU. Sixteen responses were collected. The questionnaire assessed the frequency of ITU step-downs, perceived adequacy of verbal and written handover, completion of medication transcription to EPMA prior to ward transfer, and suggestions for further improvement. Results were compared with findings from the previous audit cycle following the introduction of mandatory verbal handover, revised ITU discharge summary templates, and guidance on EPMA transcription.

Results: Respondents reported frequent receipt of patients stepped down from ITU. Verbal handover demonstrated the greatest improvement, particularly where direct doctor-to-doctor communication occurred. Transcription of medications to EPMA by the ITU team prior to ward arrival also improved significantly. Written handover via ITU discharge summaries showed some improvement but remained variable, with respondents identifying ongoing gaps in documentation of outstanding issues, future plans, and family discussions.

Conclusion: Targeted interventions have led to meaningful improvements in verbal handover and medication transcription, enhancing patient safety during ITU step-down. Written handover remains an area for further improvement. Sustained emphasis on junior-to-junior verbal handover, timely upload of discharge summaries to electronic records, and clear documentation of ongoing plans is recommended to further strengthen continuity of care.

Poster Presentations

47. Surgical Re-exploration After Adult Cardiac Surgery: A Three-Year Single-Centre Audit of Incidence, Indications and Outcomes

Amna , Muhammad Aftab, Prashanth Sadhahalli, Julia Glizvskaja, Nottingham University Hospitals NHS Trust

Introduction: Surgical re-exploration for bleeding, cardiac tamponade, or haemodynamic instability is a serious complication of adult cardiac surgery, with national estimates ranging from 0.69-7.6% (1-3.) It is associated with significant morbidity, mortality, and resource utilisation. Understanding local incidence and underlying causes is essential to guide quality improvement initiatives.

Methods: A retrospective audit was conducted over three years (01/04/2022–31/03/2025) at a tertiary cardiac centre. All adult patients requiring unplanned surgical re-exploration following aortic valve replacement (AVR), mitral valve replacement (MVR), coronary artery bypass grafting (CABG), or combined procedures were included. Data were extracted from electronic patient records. Variables collected included indication for re-exploration, procedure type, timing, location, intraoperative findings and mortality.

Results: Of 1,546 eligible cardiac surgical procedures, 75 (4.8%) required surgical re-exploration. The most common indications were haemodynamic instability 36/75 (48.0%), increased drain output 29/75 (38.7%), and cardiac tamponade 23/75 (30.7%). Re-exploration occurred following isolated and complex procedures, including CABG, valve, combined, and aortic surgery. Among patients requiring re-exploration, the most common primary procedure was isolated CABG (26.7%), followed by isolated valve surgery (24.0%), valve surgery with additional procedures (21.3%), combined CABG and valve surgery (17.3%), and aortic dissection repair (10.7%).Median time to re-exploration was 11.5 hours (IQR 4.0–11.25). Most re-explorations occurred in theatre 52/75 (69.3%), with 17 (22.7%) in CICU. Intraoperatively, a discrete bleeding source was identified in 17/75 (22.7%) and clots were identified in 28/75 (37.3%). At discharge, 51/75 (68.0%) patients were alive and 24/75 (32.0%) had died.

Conclusions: Re-exploration rates were within the expected national range, with haemodynamic instability the principal trigger. Frequent clot burden and identifiable bleeding points highlight opportunities to optimise haemostasis and postoperative surveillance to reduce re-intervention, morbidity, and resource utilisation.

Domain	n (%)
Overall incidence (of 1,546 procedures)	75 (4.8%)
Indications for re-exploration	
Haemodynamic instability	36 (48.0%)
Increased drain output	29 (38.7%)
Cardiac tamponade	23 (30.7%)
Cardiac arrest	9 (12.0%)
Index procedure type	
Isolated CABG	20 (26.7%)
Isolated valve surgery (AVR/MVR)	18 (24.0%)
Valve surgery with additional procedures	16 (21.3%)
Combined CABG and valve surgery	13 (17.3%)
Aortic dissection repair	8 (10.7%)
Intraoperative findings	
Discrete bleeding source	17 (22.7%)
Clots identified	28 (37.3%)
Outcome at discharge	
Alive	51 (68.0%)
In-hospital mortality	24 (32.0%)

Table 1: Incidence, indications, operative findings, and outcomes of patients requiring surgical re-exploration (n=75).

References:

1: Agarwal S, Choi SW, Fletcher SN, Klein AA, Gill R, et al. *The incidence and effect of resternotomy following cardiac surgery on morbidity and mortality: a 1-year national audit on behalf of the Association of Cardiothoracic Anaesthesia and Critical Care.* Anaesthesia. 2021;76(1):19–26. doi:10.1111/anae.15070.

2: Bharath B, Nikhilan N, Vijayan M, Karthikeyan K, Muthukumar M, Amirtharaj A, Baylis MM. Re-Exploration After Cardiac Surgery – Incidence, Risk Factors and Prognostic Impact. *European Journal of Cardiovascular Medicine*. 2025 Oct;15(10):552-558.

3: National Cardiac Audit Programme (NCAP) 2025 Annual Report. 2nd ed., National Institute for Cardiovascular Outcomes Research, 2025, www.nicor.org.uk/national-cardiac-audit-programme.

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For further information about SEA-UK please visit our website www.seauk.org or contact Catherine Smith, SEA-UK Administrator, c/o The Rotherham NHS Foundation Trust, Moorgate Road, Rotherham, S60 2UD or by email administrator@seauk.org

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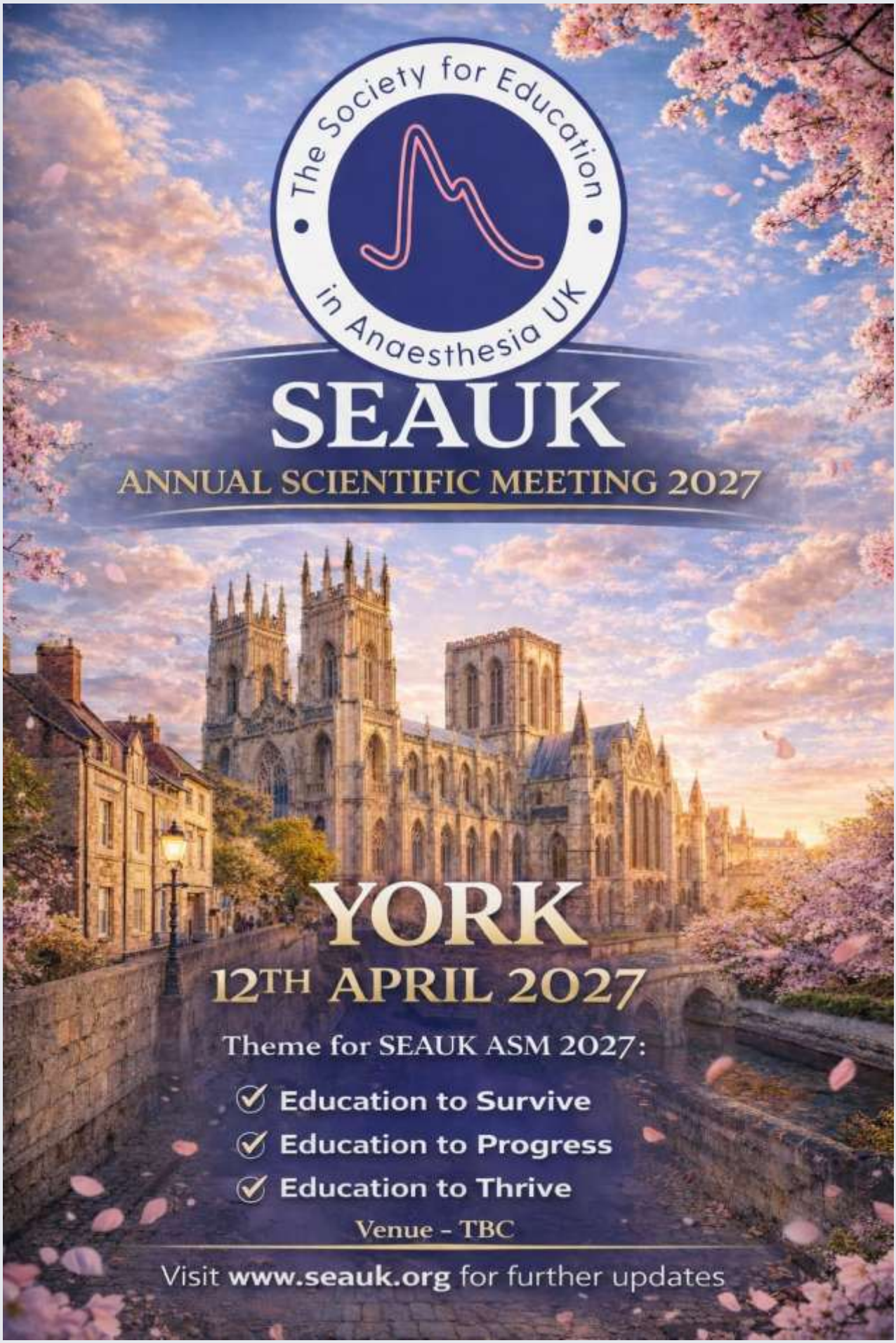
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