SEAUK

Winter 2022 Newsletter

Inside this issue...

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Join SEA-UK Today

Be part of a growing network of passionate educators in anaesthesia across the UK

The Society for Education in Anaesthesia UK is an organisation that works to provide high quality networks and professional development opportunities for education in anaesthesia in the UK and overseas. SEA-UK is here to provide the advice, support and resources you need to excel your career as an anaesthetist, trainer, educator and leader.

There are many benefits of becoming a member of SEA-UK, these include:

Keeping up to date

- Receive updates on the latest developments in educational methods with the biannual SEA-UK newsletter
- Our new website provides the latest updates in education, making it easy to navigate and find the resources you need

Free webinars

- Join and access our webinars for free

Attending CPD accredited meetings and workshops

- Discounted access to SEA-UK conferences and workshops will keep up to date with the latest developments in education in anaesthesia

Learning from others

- SEA-UK online forums provide a space for like-minded educationalists to network and share experiences and discuss future ideas for education and training (available on our website)

Collaborating with others

- Discuss the latest issues and innovations regarding the Royal College of Anaesthetists' training curriculum and the opportunities and challenges for trainees and trainers
- Get support from trainers and educators from across the UK

Building your portfolio

- Submit articles on educational topics for free. These are published in our biannual newsletter or in the RCoA Bulletin magazine
- You will be a member of an organisation that has a national influence on anaesthetic education and development

Thank you for your time and we look forward to you joining us here:
https://www.seauk.org/join-seauk

SEAUK

Kind regards,

Cyprian Mendonca	Peeyush Kumar	Claire Halligan	Umair Ansari
President	Secretary	Treasurer	Webmaster

WELCOME

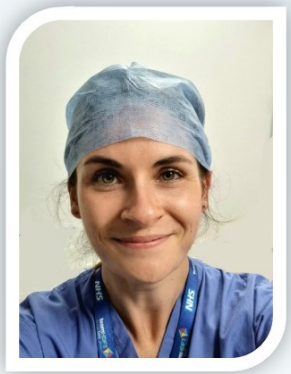
Letter from the Editors

SEAUK

SEAUK
Established 1999
Charity Number 1091996
Winter Newsletter 2022
Editors: Rachel Holmes,
Sue Walwyn
Design: Rachel Holmes 2022

Inside this issue

Dear Reader,



A very warm welcome to the SEA-UK Winter Newsletter 2022.

Thank you for picking up, or downloading this issue which provides some hearty reading on anaesthesia educational topics.

Since our July newsletter, we welcome two new committee members. Dr Cliff Shelton who joins us as scientific officer, and Dr Moahmed Abdul-Latif our editor who will be working on our next newsletter in July 2023.

The society hosted two webinars, the first in partnership with the Association of Anaesthetists of Great Britain and Ireland 'FRCA, The Road to Success' which had a global audience with attendees from across the UK, Ireland, Ghana, Lithuania and Australia. The second on 'Developing Reflective and Professional Anaesthetists', where we welcomed guest speakers who gave excellent talks on topics such as role modelling, reflection and supporting international medical graduates. Please find the summaries of the talks on pages 9 to 12.

Congratulations to all those who received grants from SEA-UK to undertake invaluable projects contributing to education in anaesthesia. From developing eLearning programmes, to helping overseas trainee anaesthetists excel their professional development, each of these grants has been used for valuable projects in anaesthetic education. Their write ups can be found on pages 13 to 18. Also, congratulations to our essay winner Dr Hisham Riad for his essay on less than full time training, which can be found on pages 19-20.

We have some additional articles of interest in our special features section covering the state of education and workforce report, final FRCA preparation, and multidisciplinary human factors, simulation and ACCS training. All incredibly relevant to us all in the modern world of anaesthesia, find these on pages 21-29.

Wishing you all a very Merry Christmas and a Happy New Year and we look forward to seeing you at our ASM next May.

Yours faithfully,

@SEATWEETUK

Rachel Holmes
Junior Editor

With guidance from
Dr Sue Walwyn, Immediate Past President

Featured photograph page 1
View from Anne Boleyn's Seat, Fountains Abbey
Rachel Holmes 2022

SEAUK

Letter from the President

Professor Cyprian Mendonca

Welcome to the SEA-UK Winter Newsletter 2022

I hope this newsletter reaches you in a great festive atmosphere of celebration. We have had a busy year with exciting developments. Following the successful delivery of our face-to-face annual scientific meeting in May, in collaboration with Association of Anaesthetists we delivered an online webinar on "FRCA exams - the Road to Success" in September to help both the trainees and trainers in exam preparation. The webinar on 'Developing Reflective and Professional Anaesthetists' in November was attended by nearly 400 delegates and received very positive feedback with abundant praise.

We are continuing to deliver two free webinars in 2023, so don't forget to leave space in your diary for the March webinar. Our next Annual Scientific Meeting will take place on 15th of May in Cambridge with the theme of trainee support and personal development. Don't miss the opportunity to visit Cambridge and attend the ASM. Our members are encouraged to apply for our four annual educational grants available throughout the year.

I am very pleased to see the membership is strengthening day by day, and continuing innovations in education. We are updating our website with new materials, so please visit the educational forum and contribute to discussions on educational challenges.

Wishing you all a joyful festive season and Happy New Year.

Cyprian Mendonca

Cambridge 2023

The 23rd Annual Scientific Meeting

15th May 2023

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Society for Education in Anaesthesia

23rd Annual Scientific Meeting

15th May 2023

Trainee Support and Development

- Supporting trainee with neurodiversity
- Equality & Diversity in education
- Unconventional career opportunities
- Interprofessional education
- Trainee as a teacher
- Hot topics in medical education

Møller Institute Cambridge

Organisers: Dr Vishal Patil and Dr Kiran Salaunkey Cambridge

Register using the link or QR code
https://bookcpd.com/course/seauk-asm-2023

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Cambridge 2023

The 23rd Annual Scientific Meeting—Programme

15th May 2023

SEA UK

Society for Education in Anaesthesia (UK)
Registered Charity No. 1091996
23rd ANNUAL SCIENTIFIC MEETING
Monday 15th May 2023
Venue: **Møller Institute, Cambridge**

8:15	Registration	
8:45	Introduction and Welcome	Professor Cyprian Mendonca President SEA UK
	Session 1	Chair: Dr Claire Halligan
09:00	Supporting the Trainee with Neurodiversity	Dr Jennifer Taylor University Hospitals of Leicester NHS Trust
09: 25	Equality and Diversity in Medical Education	Professor Partha Kar Portsmouth Hospital NHS Trust
09: 50	Interprofessional Education	Dr Sharon Buckley University of Birmingham
10: 15	Questions and answers	
10: 30	**Refreshments**	
11: 00	**Session 2**	Chair: Dr Vishal Patil
11: 00	Unconventional career opportunities 1	Dr Mark Slack CMO and Co-founder of CMR surgical
11: 25	Unconventional career opportunities 2	Dr Steven Bishop Director of Clinical and AI at Flok Health
11: 50	Unconventional career opportunities 3	Dr Simon Lambden Head of Medical Sciences, Inotrem
12: 15	Unconventional career opportunities 4	Dr Tim Baker Cambridge University Hospitals NHS Trust
12: 40	Question &Answers	
12: 55	**AGM**	
13: 15	**Lunch**	
14: 00	Free Paper Session	Chair: Dr Cliff Shelton
15: 00	**Refreshments**	
	Session 3	Chair: Dr Kiran Salaunkey
15: 30	Trainee as a Teacher	Dr Nicola Jones Royal Papworth Hospital Cambridge
15: 55	Educational Fraud	Dr Andrew Klein Royal Papworth Hospital Cambridge
16: 20	Hot topics in Medical Education	Dr Catherine Bennett University of Warwick
16: 45	Question &Answers	
17: 00	Presentation of prizes and closing address	

Register using the link or QR code
https://bookcpd.com/course/seauk-asm-2023

Cambridge 2023

The 23rd Annual Scientific Meeting—Call for Abstracts 15th May 2023

The 23rd SEA-UK Annual Scientific Meeting will be held at the Møller Institute, Cambridge on 15th May 2023.

This call for abstracts is unrestricted, however prizes will only be awarded to trainees

Prizes:
Oral presentation: Two prizes
Poster presentation: Three prizes

Deadline for submissions
5pm on 17th March 2023

Submitting an Abstract – Guidance notes

Your submission must be related to an educational topic. We are not a forum for purely clinical presentations. All submitted abstracts will be assessed and ranked. The top six abstracts will be chosen for oral presentation and will be judged on the day for the prizes. If you wish to have your work to be presented as poster only, you must specify at the time of submission. All posters will be judged on the day for the prizes.

Abstract should include:

- Title, authors (identifying speaker and grade), employing institution
- Introduction/methods/results/discussion or conclusion
- Abstracts should be no more than 300 words in length (excluding the title, authors and up to three references)
- Maximum one table or a graph or a figure can be in included
- Results must be included in the abstract, rather than stating "results will be presented"
- No smaller than Arial font size 10
- Include whether your submission has been previously presented anywhere (this is generally acceptable providing results are still recent)
- You may submit more than one abstract, providing all work is distinct from each other

Please send to Dr Peeyush Kumar, Abstracts Co-ordinator (**secretary@seauk.org**) with a copy to Cath Smith, Society Administrator (**administrator@seauk.org**) as a Word document, by **5pm on 17th March 2023**. Late submissions will be rejected.

In submitting an abstract you confirm that you, or the presenting author, will register and pay to attend the conference. When submissions are accepted, all participants must confirm their involvement by registering and paying the conference fee by **Friday 21st April 2023**. We cannot guarantee that presenters who miss this deadline will be included in official conference publications including the abstract book.

The abstracts will be judged by a panel of the SEA-UK 2023 abstract team. The corresponding author will be notified by 31st March 2023.

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SEA-UK Webinar March 2023

SEAUK The Society for Education in Anaesthesia

Webinar

Supervision and the New ACCS Curriculum

Date: 9th March 2023 Time:18:00 - 20:00

- Overview of GMC's Educational and Clinical Supervision Requirements
- Supervision of CT1 & CT2 doctors: Challenges and Practical tips
- Trainee's perspective of new ACCS curriculum

Register here: https://tinyurl.com/SEAUK0323

No Registration fee

SEA-UK November Webinar

Developing Reflective and Professional Anaesthetists

Fostering the Reflective Practitioner

Dr Sarah Thornton
Consultant Anaesthetist, Royal Bolton Hospital
Council member of RCoA and Deputy Chair of Education, Training and Exams

Summarised by Dr Sue Walwyn, Immediate Past President

Dr Thornton introduced the session by emphasising the role reflection has in learning. In fact reflection is the key to learning throughout professional life, but it remains difficult to teach.

The role of reflection and teaching reflection was further explored with relation to progression from novice to mastery and global professional development. Involving the use of role modelling and focussed feedback, encourages a process of guided reflection. An example was used demonstrating how to address lack of insight in a manner which encouraged the individual to review their behaviour, reflect on how they wanted to be viewed by the person providing both immediate and delayed feedback and change their behaviour.

As teachers we are role models but how do we firstly make sure that we are providing appropriate teaching and secondly that we can incorporate this into our daily routines? One of the suggestions was to actively seek feedback from the trainee or person being taught. For example, finding out what was learnt when debriefing after a teaching session. Another suggestion which is commonly used followed the process of the LOAF and BREAD educational checklist. This is a useful method of formalising the process and could be used for the learner or the teacher. https://loafnbread.com/the-starter-pack/.

As Dr Thornton pointed out, it is not just giving feedback but the process which is so important to positive forward progression. We need to be aware of what language we use and in what context. Use of language which is mindful of cultural specifics and connotations will reduce ambiguities and misunderstanding. A suggested example of positive language (the giraffe analogy) included the use of supportive, empathic and descriptive terms was mentioned. This is as opposed to the more critical and judgmental "jackal" type of language. Supportive and developmental language is more likely to encourage reflection; promoting the "flourishing" rather than "languishing" state to which we aspire in the educational culture. The Losarda ratio of 3:1 was quoted as the number of positive comments needed to outweigh a negative observation and encourage a positive learning mindset.

However, there are times when negative feedback is needed. Dr Thornton has years of experience and has developed a technique of approaching situations where this will entail asking difficult questions. Those questions such as "why, what, how, who, when and where" can be tricky to ask, but the important aspect is developing a follow up plan with the individual, providing them with mentor support and making them aware of the aspects within their own professionalism, which may need to change. The new curriculum with its emphasis on non clinical skills provides a good basis upon which aspects of emotional intelligence can be addressed. Why not do a supervised learning event looking at the ability for a learner to understand the team they are working with, and remember everyone's name?

The tendency of anaesthetists to be overly self critical is an important point with which we all identify. However, failure can be seen as a learning opportunity and should be recognised as such. Mr. Caris-Grimes provides a useful examination in the BMJ on failure and learning as a part of the growth mindset. https://blogs.bmj.com/bmj/2020/08/15/caris-grimes-clinicians-need-to-learn-how-to-manage-failure/

The talk encouraged much discussion and many questions. Ultimately, we are all on the journey of understanding reflection, developing our own ways of doing so and advising others who need direction. We are in our "conscious incompetent" phase of learning and what this talk highlighted is the need for personal understanding in order to help others develop, the requirement for insight into language of feedback and the importance of addressing problems in a supportive way.

SEA-UK November Webinar

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Developing Reflective and Professional Anaesthetists

Meeting the Differing Needs of Overseas Doctors

Professor Sujesh Bansal
Consultant Anaesthetist, Central Manchester University Hospitals NHS Foundation Trust
Honorary Professor at Manchester University

Summarised by Professor Cyprian Mendonca, President

In recent years, the number of international medical graduates (IMGs) joining the NHS has been exponentially increased. Therefore, it is essential to improve the learning environment for IMGs and locally employed overseas doctors. Although the majority of IMGs start as locally employed doctors in the NHS with career aspirations, less than half of them to progress in their career without problems.

What are the challenges for IMGs when they arrive to the UK?

When they arrive in the UK they are faced with several challenges. These involve:

- Social and support network: They suddenly lose their existing support net and need to establish a new network of friends.
- Social and cultural differences: IMGs are less likely to be familiar with legal and ethical aspects of UK clinical practice.
- Knowledge and skills: There is likely to be some gaps in their knowledge and skills requiring re-learning to match their knowledge and skills to UK clinical practice.

It is important for an educational supervisor to understand these challenges, so that their learning environment can be improved. The Fair to Refer (2019) report from the GMC makes several recommendations which are applicable to IMGs. These include honest and direct feedback, comprehensive and ongoing socialisation, a learning approach to mistakes, and a cohesive and accessible senior leadership team. However, establishing a robust support mechanism is not without challenges. It is a complex process involving multiple stake holders at their pre-transition, transition and post transition levels. A good educational supervisor should provide support to the IMG trainee at all three levels.

How can we improve the learning experience of IMGs?

Ideally, the process should be initiated during recruitment and prior to their arrival to the UK.

- Recruitment, selection and placement: Allocation of placements should be based on the individual's educational needs.
- Enhanced programme of induction should include measures to improve consultation skills, training for education and clinical supervisors, measures to minimise unconscious bias and social and linguistic support.
- Early assessment of risk enables bridging the gap in their knowledge, skills, attitude and behaviour.
- Multiple targeted sets of interventions help to improve the safety in patient care.

Three key elements of an integrated system that can improve the learning environment to IMGs include a robust recruitment, enhanced induction programme and enhanced supervision and appraisal. It is important that enhanced induction is delivered along with enhanced supervision and peer 'buddy' system to ensure continued support throughout their career.

SEA-UK November Webinar

Developing Reflective and Professional Anaesthetists

What support mechanisms are already available?

The national induction programme is now live on e-learning for healthcare since June 2022. This provides comprehensive guidance on pastoral support for IMGs, professional medical practice in the UK, language and communication induction, information systems induction and guidance on specialty induction. In addition, there are several e-learning modules including social, ethical, and legal aspects of UK clinical practice, patient safety aspects and personal wellbeing. A comprehensive peer buddy system within the department is very useful and compliments the educational supervision. Appropriate training for peer buddies is vital for successful peer buddy system. It is important that educational supervisors of IMGs understand the CESR process, as an experienced IMG may wish to enter specialist register via CESR route.

Supervising and supporting in a multi-cultural team is a challenge, hence appropriate training for supervisors is also important. IMGs should develop emotional, cultural intelligence and resilience to ensure optimum performance. To enhance the level supervision provided, faculty development sessions for educators and supervisors is essential.

Finally, to improve the learning environment of IMGs, various organisations such as educational societies, Royal Colleges, the GMC, Health Education England, the BMA, and the local trust should work in collaboration to develop support systems. Educational and clinical supervisors should be equipped with appropriate knowledge, skill and tools to provide an enhanced supervision to IMGs.

Resources

Welcoming and Valuing international medical graduates in UK (https://www.e-lfh.org.uk/programmes/nhs-induction-programme-for-international-medical-graduates/)

NHS launches first standardised induction programme for international medical graduates (https://www.bmj.com/content/378/bmj.o1624)

Specialty specific guidance for CESR in Anaesthetics (https://www.gmc-uk.org/registration-and-licensing/join-the-register/registration-applications/specialty-specific-guidance-for-cesr-and-cegpr/specialty-specific-guidance-for-cesr-in-anaesthetics)

SEA-UK November Webinar

Developing Reflective and Professional Anaesthetists

Role-modelling

Dr Kathryn Bell
Consultant Anaesthetist, The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Summarised by Dr Rachel Holmes, Junior Editor

Dr Bell has expertise in helping trainees who are 'not progressing smoothly' in their anaesthetic training. She gave an insightful talk on the importance of trainers role-modelling for anaesthetic trainees, knowledge which she has gained from her own experience in her pastoral role. Drawing a number of parallels between learning how to become an anaesthetist and training to become a Star Wars 'Jedi', mastering the 'force' of anaesthesia involves learning from those we look up to. Role-modelling is important in many professions, but is seldom discussed in education in anaesthesia.

Dr Bell also drew comparison of curriculum changes over the years from a 'blank canvas', where the trainee is responsible for creating their own training, to a 'Mondrian' style structured approach. The Royal College of Anaesthetists' curriculum has transitioned, particularly very recently, into now what seems a Jackson Pollock canvas of complexity. These recent curriculum changes have made it difficult for trainers to keep abreast of both delivering anaesthetic education while fulfilling the training needs now required.

Despite the complexity of modern anaesthetic training and the difficulty in navigating this, there is one thing that we can all agree on. Trainees want to learn how to master anaesthetics from their trainers. An important part of this is demonstrating qualities that the trainer wants the trainee to adopt (role modelling), and a conscious appreciation of this is needed.

Dr Bell discussed both the value of conscious role modelling (maintaining quality, motivating trainees, and reinforcing positive behaviours) and it's importance (helping individuals progress). Its importance is also in writing, as a key capability in the new curriculum. Though it is not clear what the college wants from trainers or trainees to achieve this competence.

Conscious role modelling can give a trainer a better angle to give and receive feedback. A good framework that can be used is a describe or demonstrate (a behaviour or value), delineate (break it down into bitesize chunks) and debrief (describe the narrative or outcome) structure.

Teaching both technical and non-technical skills is an important part of being a role model. Using the 'seven Cs' of communication can help a trainer focus on how to get some of these skills across (clear, correct, complete, concrete, concise, consideration and courteous).

Dr Bell was asked who her role models were, and she replied 'the professionals who always put the patient at the centre of everything they did', and reflected on how this lead her to her career in anaesthesia. As a final reflection, the panel discussed how trainers can't always be the perfect role models, and indeed part of role modelling is for the trainee to see the 'rough edges'. There is value in seeing a doctor have a bad day, and how they cope with it is a learning experience in itself.

Number 34
Jackson Pollock, 1949
Oil and Enamel Paints on paperboard

SEA-UK Grants Project Reports

Using Virtual Education as a Means of Enhancing Professional Development for Zambian Anaesthetic Trainees

Dr Rebecca Jackson
Consultant Anaesthetist
University Hospital of Wales

In January 2021, I was fortunate enough to be awarded an educational grant from SEA-UK. At the time I was undertaking a six-month placement with the Zambian Anaesthetic Development Programme (ZADP) as a remote fellow. ZADP is an international partnership that supports the training and mentorship of physician anaesthetists in Zambia. Generally, fellows are based in country. However due to travel restrictions associated with the COVID-19 in 2021 a new remote fellow role was developed with fellows volunteering from home and supporting Zambian anaesthesia trainees remotely. The focus was on the non-clinical aspects of training therefore involved remote teaching support, exam preparation and quality improvement project (QIP) mentorship. During 2021 -2022 several anaesthetic conferences were held virtually. This made them far more accessible for Zambian anaesthetic trainees to attend and provided an opportunity to fulfil many important aspects of their training and professional development. We therefore decided to apply for SEA-UK educational grant to cover the cost of conference attendance fees.

Project objectives and design

The project was designed to use virtual education as a means of fulfilling several non-clinical aspects of the postgraduate education of Zambian anaesthetic trainees. Therefore, our project objectives were as follows:

1. Identify suitable virtual educational conferences.
2. Invite all anaesthetists undertaking their training in Zambia to submit an expression of interest if they wish to attend one of the conferences identified.
3. Connect all trainees who have ongoing or recently completed QIPs with a mentor to support them with abstract submission to a relevant virtual scientific meeting if appropriate.
4. Support any trainee wishing to submit any case report to a virtual conference

Impact

Following discussion with senior Zambian Anaesthetists, Euroanaesthesia 2022 (EASIC) was identified as suitable conference. All six of the anaesthetists in training who submitted an expression of interest in attending were able to join virtually. Many expressed the importance of attending international conferences such as this in improving the overall perioperative care and morbidity in Zambia. Many are acutely aware of the low number of anaesthetists per population in Zambia and therefore feel having the ability to hear expert opinion and evolving evidence-based practice is all the more important. Others felt it gave them an opportunity to pursue their own interest of medical education and pass the knowledge they had acquired onto their peers. It also allowed some to focus their learning on a specific aspect of anaesthesia with some feedback as follows:

> *"Topics such as Imposter Syndrome and how to prevent them, simulations and debriefs were amazing.*
> *Many are the times we have had critical incidences but I've never witnessed any debrief which I think if implemented will improve the delivery of health care and outcomes.*
> *I enjoyed every single Obstetric presentation I listened to and I have developed so much passion for Obstetric Anaesthesia. Hoping for more of these conferences."*
> *"I can only get better meeting the great minds at the European Society of Anaesthetists 2022 conference as a virtual attendee and do right by my patients with the knowledge and skills"*
> *"Whatever I hope to gain from this will certainly help take the specialty where it can potentially be in LMICs.*
> *I am passionate about continuing medical education amongst my peers and medical students. I strongly believe knowledge should always be shared and not hoarded"*

SEA-UK Grants Project Reports

Additionally, four trainees had their scientific work accepted for presentation at an international conference. These included three QIPS and one case presentation. The conferences included the Evidence Based Perioperative Medicine (EBPOM) 2021 conference, Euroanaesthesia 2021 (EASIC) and The Global Anaesthesia, Surgery & Obstetric Collaboration (GASOC) Annual conference 2021.

Following on from this project two more trainees have had their QIPs presented at international conferences. A joint virtual journal club facilitated by GASOC was held between ZADP and the Ethiopian Anaesthetic Development Program, with trainees from both Zambia and Ethiopia presenting.

Summary

Over a period of eighteen months this project utilised the increasing familiarity of virtual learning as a means of enhancing the education and professional development of Zambian anaesthetists in training. The majority were able to access educational meetings that they had previously not had the opportunity to do so without significant financial costs. It has allowed them to fulfil many of their non-clinical aspects of their training and develop their interests in particular aspects of anaesthesia. Furthermore, whilst a virtual component to conferences has remained an option, they have continued to successfully submit and present their academic work within an international scientific forum.

Acknowledgement

This project was funded by a SEA UK educational grant.

SEA-UK Grants Project Reports

Optimising the Knowledge and Skills of Operating Department Practitioners (Anaesthetic Assistants) on Confirmation of Tracheal Intubation—A Patient Safety Initiative

Dr Matthew Bishop
ST6 Anaesthetic Registrar, University Hospitals Coventry and Warwickshire NHS Trust, Coventry

The 4th national audit project of the Royal College of Anaesthetists and Difficult Airway Society recommended monitoring end-tidal carbon dioxide ($ETCO_2$) during intubation.[1] Along with direct or indirect observation of the tracheal tube passing through the vocal cords, the presence of an $ETCO_2$ trace on the monitor confirms correct endotracheal tube placement at intubation. There have been recent incidences of unrecognised oesophageal intubation resulting in hypoxic brain injury and death. In the recent case of Glenda Logsdail, the primary anaesthetist was convinced that the tube had been correctly placed and the critical incident was diagnosed as anaphylaxis.[2] The team was then fixated on a single diagnosis of anaphylaxis without considering the differential diagnosis of oesophageal intubation.

In order to improve patient safety and help reduce the risk of similar future clinical incidents, we propose a mandatory two-person check of correct placement of all endotracheal tubes. This would involve observation of the video laryngoscope screen by both practitioners, verbal confirmation that the tube has been seen to pass through the cords by the airway operator and assistant and subsequent two-person confirmation of the presence of $ETCO_2$ seen on the monitor. This should be achievable in an operating theatre setting as in the United Kingdom the presence of Operating Department Practitioners (ODPs) or anaesthetic assistants is mandatory during induction of anaesthesia and airway management. This two-person check, however, requires knowledge, skills and the ability to speak up.

The first phase of this project involved the distribution of a questionnaire to anaesthetic assistants across three hospital sites in the West Midlands. The sites included were University Hospitals Coventry and Warwickshire, Warwick Hospital, and the Good Hope/Solihull sites of University Hospitals Birmingham. We collected demographic data, asked questions about common capnography traces through matching of visual interpretation with descriptions, as well as anatomical landmarks relevant to laryngoscopy. We also collected data on the ability of the ODP to challenge an anaesthetist on an intubation, and speak up about any concerns regarding the correct placement of the tube, and whether they knew of the 'No Trace = Wrong Place' campaign.

The second phase of the project involved the production of an educational package to improve the knowledge and confidence of the ODPs working in these Trusts with regards to capnography interpretation and laryngeal anatomy to improve patient safety in the future, and possibly implement a mandatory two-person check at each intubation. The anaesthetic assistants were provided with an e-learning module to complete, which provided the necessary information about these important topics. They also undertook face-to-face teaching sessions led by consultant anaesthetists, who reiterated the content of the e-learning modules and provided further information and clarification where necessary.

SEA-UK Grants Project Reports

We presented the results of the initial survey in full at the SEA-UK Annual Scientific Meeting 2022. A total of 96/163 (59%) anaesthetic assistants from all three hospitals responded to the initial survey. Following the educational package roll-out, a further 64 anaesthetic assistants from a single site (University Hospitals Coventry and Warwickshire NHS Trust) responded to a follow-up survey. 64.3% of the capnography and anatomy questions were answered correctly before the teaching programme, and this improved to 88.6% following completion of the educational package. Only 59 (61.4%) of participants knew of the 'No Trace = Wrong Place' campaign prior to the study, with 100% stating they had now heard of the campaign after completion. In the original survey 66% of anaesthetic assistants stated they would feel "very comfortable" raising concerns with their anaesthetist about the $ETCO_2$ trace, while 52% stated they would feel "very comfortable" raising concerns about visualisation of the ETT position. This reduced to 39% and 41% respectively when assessed at the follow-up survey. All of the respondents, however, reported that they agreed that the educational package was helpful with regards to capnography interpretation and knowledge of anatomy for laryngoscopy, with 83% and 81% respectively stating they strongly agreed.

The original survey highlighted shortcomings regarding knowledge of the effective interpretation of capnography and of basic laryngeal anatomy in this cohort of anaesthetic assistants. It is important that when anaesthetic assistants do challenge their anaesthetist, that their input is backed-up by sound reasoning and knowledge, so the introduction of an educational package has been shown to improve their understanding and analysis of the information relevant to confirmation of successful tracheal intubation. Although their level of comfort in raising concerns with the anaesthetist regarding correct placement was not improved, overall, the candidates felt this educational intervention was beneficial. The follow up survey was completed with a greater proportion of novice anaesthetic assistants (0% pre- vs 37.5% post-education) and this could explain the reluctance to speak up.

References

1. T. M. Cook, N. Woodall, C. Frerk, on behalf of the Fourth National Audit Project, Major complications of airway management in the UK: results of the Fourth National Audit Project of the Royal College of Anaesthetists and the Difficult Airway Society. https://doi.org/10.1093/bja/aer058
2. https://www.judiciary.uk/wp-content/uploads/2021/09/Glenda-Logsdail-Prevention-of-future-deaths-report-2021-0295_Published.pdf

Acknowledgement

This project was funded by a SEA UK educational grant.

SEA-UK Grants Project Reports

Whatever Next? A Random Patient and Scenario Generator in Anaesthetics and Critical Care

Drs J Wilkinson, J Wilkinson, S Redford, M Faulds.
Newcastle upon Tyne Hospitals NHS Foundation Trust

A random patient generator (RPG) is a way of rapidly constructing a hypothetical patient or scenario that can be used to facilitate teaching or discussion. Learning during these discussions is achieved by progressing from unistructural knowledge to multi-structural or relational understanding.

Development of our RPG began in August 2020. We commenced by producing handwritten address cards containing assorted variables that could be shuffled to produce the random scenario. This has evolved to a basic electronic version, simply a spread sheet. We used the early iterations of the RPG to facilitate discussion and learning at a number of small group teaching sessions. Feedback from attendees was universally positive and all participants (including those facilitating the session) reported leaving with either something to reflect on or having deepened their understanding of a topic.

In March 2021, we received grant from SEA UK to initiate this project. Over the past year and a half, we have continued to use the RPG in a number of departmental teaching sessions. Receiving positive feedback and exploring different applications and session types.

We have used the funding to produce an initial version of the website which can be accessed at the following address: http://whatever-next.org

Moving forward with the project and educational concept there are plans to expand the website to include random patient and scenario generators optimised for hosting discussion-based sessions with alternate themes and audiences to Anaesthetics and Critical Care including, medical students and General Practice.

There are ongoing efforts to package the RPG into an App but at this stage has proven financially prohibitive. Hence the decision to create a website which can be easily viewed on a mobile device as an intermediate step.

The interest in random patient generator sessions was originally born out of the need for online teaching sessions (due to the pandemic). As normality has returned and face to face teaching sessions have recommenced the RPG sessions have continued to remain interesting and interactive with positive participant feedback. Ideally these sessions are hosted with the use of a projector and laptop so that all participants can see the scenario developing. To help these sessions continue to run we have used the remaining funding to purchase a digital projector for the Anaesthetics and Critical Care education department to run these sessions.

John Wilkinson
Anaesthetics Registrar
Northern Deanery

Acknowledgement

This project was funded by a SEA UK educational grant.

SEA-UK Grants Project Reports

Developing eLearning for Anaesthetic Training

Dr Tom Lawrence
Consultant Anaesthetist, Leeds Teaching Hospitals Trust

The new RCoA curriculum puts increased emphasis on certain areas that are becoming more and more prominent in modern anaesthetic practice. One of these areas is sedation, where a focus on safety as well as increasing complexity of procedures carried out under sedation has led to a steady increase in anaesthetist delivered sedation.
As part of the response to this increased emphasis The Yorkshire & Humber Deanery planned several learning resources, from face-to-face teaching to electronic resources. As I had recently created an eLearning package on Sedation for non-anaesthetists for Leeds Teaching Hospitals I was asked to produce a similar package for Stage 1anaesthetic trainees.

My interest in digital learning paradoxically stems from a dislike of eLearning! Digital learning has great potential, however too often it is employed ineffectively. Anyone who have trawled through hours of mandatory eLearning packages will know that knowledge retention falls rapidly (even the most optimistic studies suggest after 20 minutes). This is combined with the problem that eLearning is often employed by organisations to demonstrate they have taught something, rather than ensure someone has learned it.

When producing the eLearning for my trust I worked with the Medical Education department and they facilitated the technical side. This time I was to produce the eLearning myself which was daunting. Although I am relatively tech-literate I have never put together a package such as this before.

After some research it became clear that the two main options were Articulate, and Adobe Captivate. Reviews seemed to be equal between the two, and as the previous eLearning was created in Articulate I had some experience with the system and so I opted for this. Both are a subscription-based service which is increasingly common in professional software. Articulate offers a suite of software within the subscription, with options aimed at tech-novices, all the way up to experienced content creators. One feature I found particularly useful was the ability to build a package in an easy to use format but import sections or objects from the more tech-involved software. This allows you to slowly incorporate more complex items into your eLearning without having to take the plunge into the more involved side of the software straight away. I explored several options to acquire funding for the software, with a generous SEA UK grant being the eventual source.

As with all educational materials content is the bedrock. I drew on the existing work I had done for my trust, the curriculum objectives as well as existing eLearning material available including that from the RCoA on eLearning Anaesthesia (eLA). My aim was to provide the information in an easily digestible format without overloading the learner. This was important for two reasons. First this is aimed at Stage 1 anaesthetists who will be learning about sedation possibly for the first time. Secondly regardless of the experience level of the learner knowledge retention drops off dramatically after roughly 20 minutes of online learning.

Other techniques I employed were to provide obvious dividing sections in the eLearning and encouraging people to do the eLearning in several sittings. Regular switching between learning styles (text, visual, and videos with audio) aimed to optimise knowledge retention and cater for a number of learning styles.

The product was better than I had hoped for and took less work than expected. As it is the first package I have produced I hope to put to use the skills I have picked up in the first endeavour to improve on projects to come.

Acknowledgement

This project was funded by a SEA UK educational grant.

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80% Less Than Full Time Should be the New Normal. How will this Affect the Future Workforce?

Dr Hisham Riad
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Introduction

Equilibrium is a term rarely used outside of the context of anaesthetic exams. It refers to a state of balance. The work-life balance required to achieve equilibrium is often overlooked, and is something, as an anaesthetist in training, I have often found challenging.

Doctors traditionally place patients before themselves, however increasing cases of burnout in the profession demand a resolution by moving towards a satisfactory work-life balance.

In a notion to support less than full time (LTFT) work as the norm, this essay explores the benefits and challenges associated with 80% LTFT as a potential solution to restoring balance and considers the likely impact on the future anaesthetic workforce.

Background

Health Education England define LTFT training as a restriction in the number of hours worked (1). LTFT trainees must satisfy the same training requirements as their full time (FT) counterparts, which necessitates an extension in their training time. Historically, LTFT training was permitted only when a trainee fulfilled specific eligibility criteria, making LTFT inaccessible to most. Now, following recent legislative changes, all trainees are eligible to apply for LTFT by citing a requirement for a better work-life balance (1). This is an important step towards recognising and supporting a cultural shift towards flexible working.

Benefits

Doctors are human too, and LTFT recognises the importance of commitments outside of work such as health, family-life, and religion, thereby supporting a healthy life-balance. This in turn translates to a happier workforce and improves staff retention. In a large survey of LTFT and FT trainees, LTFT trainees reported feeling more enthusiastic and satisfied in their work compared to their FT colleagues. Moreover, 93% of LTFT trainees agreed that restriction to working hours had increased their likelihood of remaining in training (2).

Importantly, LTFT training can be a helpful support for doctors with disabilities. As the medical workforce rightly moves to reflect the population it serves, naturally there are increasing numbers of medical students and trainee doctors with disabilities. Making LTFT training the norm may remove the barriers and stigma associated with disability, and further improve retention of a diverse workforce.

Challenges

Prejudice

LTFT working was not openly discussed during my medical school training. Therefore, it was only during my transition to foundation year training that I encountered LTFT colleagues. Due to my lack of understanding around LTFT training, I ashamedly believed these colleagues lacked resilience and assumed their clinical skills and knowledge would be weaker than FT trainees. My personal education and reflection since have allowed me to understand the need and benefit of LTFT training. Subsequently, my perception has shifted. However, a negative culture remains around LTFT work that we cannot overlook. In a 2012 national survey exploring experiences of flexible working in over 800 surgical LTFT trainees, more than half reported undermining behaviour (3). This statistic is harrowing. Qualitative comments from the same survey also highlighted negative attitudes from older consultants and difficulties liaising with human resources (3). These are just some of the barriers towards accessing LTFT training.

Following the impact of the COVID-19 pandemic there has been greater recognition of the need to support trainee wellbeing and the positive influence of flexible working (1). However, if LTFT work is to be established as the norm, education for healthcare and administrative staff is required to shift the culture towards acceptance of LTFT within the National Health Service (NHS).

Organisation for trainees

Whilst LTFT work has many benefits, the administrative burden is huge.

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LTFT work alters annual leave, study leave and bank holiday entitlement pro rata, as well as changes to pay and pensions (4). This often necessitates careful planning and financial advice.

It should be recognised that mandatory subscription costs, courses, and examination fees are usually not reduced for those on LTFT wages and may subsequently place a trainee under financial stress. This is certainly an area that will require consideration if LTFT becomes the norm.

Some of these difficulties can be mitigated by ensuring that support and information is freely available for those considering LTFT work. Indeed, since the 2018 junior doctor contract review, it is now mandatory for all LTFT trainees to have access to a Champion of Flexible Working; a role designed to help support and advocate for LTFT trainees (4).

Workforce planning

Difficulties with workforce planning remain a strong counterargument to LTFT work. Incorporating LTFT workers on electronic rotas that have specific rules applicable to FT work is undoubtedly challenging. However, guidance exists to support the development of rosters for LTFT trainees (4). In addition, with early planning and dialogue, a compromise to suit employer and employee can often be found.

To be eligible for a consultant anaesthetic post, trainees must complete a minimum of 7 years of competency-based training according to the Royal College of Anaesthetists (RCOA). As such, a 7-year time interval is often used in workforce planning. However, data from a 3-year review of anaesthetic trainees from the RCOA identified that the length of training for FT trainees was an average 8 years 5 months (3). Reasons for extension in training included maternity leave, out of programme experience and failure to pass examinations. It feels appropriate therefore to argue that the present workforce model is outdated and must be adapted to reflect this extended training time needed to complete anaesthetic training.

LTFT anaesthetic trainees spend an average of 10 years 8 months in training (3). Superficially it would seem that workforce planning would be made more difficult and expensive. However, by improving flexibility to working, we increase morale and work satisfaction, thus reducing the considerable attrition rate from the NHS and ultimately improving staffing levels. This would make workforce planning easier and more sustainable for the future.

Conclusion

As explored, LTFT supports both trainee wellbeing and the future anaesthetic workforce. Whilst incorporating this mode of working will require an enormous level of organisation and structural change, I feel that this can be justified by the positive impact on the workforce. It is clear there is a growing cultural shift towards LTFT as a valid lifestyle choice amongst trainees. With cooperation and open-mindedness, I believe 80% LTFT can and should replace the FT status quo to restore a healthy work-life equilibrium.

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The State of Medical Education and Workforce Report

Dr Sue Walwyn, Immediate Past President
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The state of medical education and workforce report (https://www.gmc-uk.org/-/media/documents/workforce-report-2022---full-report_pdf-94540077.pdf?la=en&hash=9267A7B904842B44133BC982EEB3F5E8ED1A85F4) highlights the increase of 17% in the NHS Medical workforce size over the last 5 years, the majority of which can be attributed to the increase in International Medical graduates (IMGs). In addition there has been a large increase in the number of non consultant doctors, which bodes well for the predicted shortfall of anaesthetists quoted in the RCoA workforce report published in February 2022 (https://www.rcoa.ac.uk/sites/default/files/documents/2022-02/State-Nation2022.pdf) but has consequences for provision of induction, support, supervision and education.

There has been a six times increase in number of SAS and Locally Employed doctors (LED) nationally and the growth of SAS doctors is four times that of the specialist doctors since 2017. Although there has been an increase in undergraduate places and output (8000 in 2018/8 to 10,543 in 2021/2) the increase in the last year has been attributable to the increase in IMG doctors (>50%) This is with particular reference to England which is the devolved nation with the greatest increase in IMG doctors.

The report looks at those leaving and of the IMG doctors who join the NHS a large proportion leave with only a third of these going back to their original country of residence. This rate was significantly higher in the period November to April 2022 but no suggestions were seen with regards to the reasons why. Other figures of interest in this area are the preponderance of male leavers (pensions would be expected to be the main reason but actually account for a very small proportion), the relatively stable recruitment proportions of women recruited and staying int he services and the small number of black doctors both in post graduate medical posts and in management. The recording of sexual orientation and disability is still new and will need longer to form an accurate representation.

So where does this leave educationalists? The traditional model has allowed for national involvement in the post graduate trainee program with local trust provision of supervision, support and education programmes for non trainee anaesthetists. The numbers quoted above refer to national statistics but anaesthetics has had a large increase in LED's and SAS doctors in the last few years. Reasons include the lack of mobility during and after covid, the changes in exams, recruitment and curriculum and the competitive ratio's for limited numbers of posts. There have been increases in ST numbers due to local expansion and increase in single stream ITU numbers, but this has not affected the recruitment bottleneck to any great extent. The outcome is that these doctors need specific and specialised supervision, in order to facilitate and evidence training, as well as participating in local appraisal processes. These doctors are able to use the lifelong learning platform to accumulate evidence and may still expect to sit the post graduate exams. If successful they may want to apply for ST training, hoping for a reduced overall training time.

Career progression is an important aspect of workforce wellbeing and the introduction of the new SAS contract, with associated possibility of progression and specialist doctor appointment, has provided options for some. Alternatively, the CESR pathway has enjoyed a resurgence and is likely to increase in popularity for both local and International Medical Graduate doctors. This is a lengthy process overseen by the GMC and RCoA and involves dedicated paperwork accumulation, organisation and presentation in addition to continuing the day job. For those supervising and sponsoring a knowledge of the process and requirements in useful:
https://www.gmc-uk.org/registration-and-licensing/join-the-register/registration-applications/specialist-application-guides/specialist-registration-cesr-or-cegpr).

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The NHS has always been diverse but over the last few years there has been a large increase of new entry IMG doctors. This has mostly been from South Asia with more doctors from Africa, Middle East and China. Registration with the GMC follows a set course depending on the country of origin. Those graduates from non English speaking countries outside of the EU follow the PLAB route, whilst others might have an Accepted Overseas registration exam (for instance those from Australia and Canada) or a recognised European qualification from the EU with no required need to sit the PLAB exams. The entry requirements may involve local or national sponsorship as with the Medical training Initiative scheme. Although these doctors have a limited tenure many stay for longer. Supervision of these doctors will require specialist knowledge of both the normal trainee supervisor pathway and the aspects of importance for IMG doctors. This journey starts with recruitment , involves a suitable induction and a personalised supervision pathway. There is more emphasis on educating supervisors, trusts and educational institutions but there needs to be more investment because a proportion of IMG doctors leave before the end of their tenure. It is worthwhile looking at the e-learning (July 2022) on induction for IMG doctors:
'Welcoming and Valuing International Medical Graduates: A guide to induction for IMGs recruited to the NHS': https://www.e-lfh.org.uk/wp-content/uploads/2022/06/Welcoming-and-Valuing-International-Medical-Graduates-A-guide-to-induction-for-IMGs-WEB.pdf)

As educators we need to be aware of the need for cultural competence and provide a safe environment within our own departments.

Diversity Representation within anaesthesia is evident in the data breakdown. Although there is gender equivalence across the specialty, there is less of a Black, Asian and minority ethnic presence compared to White, particularly with Black representation within anaesthesia and intensive care. Furthermore, the lack of cross cultural representation is also evident within management both in anaesthesia and intensive care. Although there are measures to increase non White medical school applicants, this does not seem to follow through in anaesthetic recruitment or evidence of post graduate training.

The recent report provides food for thought. Within education in anaesthesia we need to be aware of the large number of non trainee anaesthetists, their training needs and options for career progression. We need to be equipped to provide this support and supervision so that we can continue to provide excellent education and safe health care.

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Multidisciplinary Human Factors Training

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Dr R. Natarajan
Consultant Anaesthetist, Warwick Hospital, South Warwickshire University Foundation Trust

The benefit of multidisciplinary simulation to technical and non-technical skills has been frequently demonstrated (1) with more recent studies showing improvement in patient outcome (2). With recent changes in operating locations and environments, combined with staff re-deployment and newly qualified staff there is unfamiliarity with local emergency procedures. The anaesthetic department at Warwick Hospital attempted to address these training requirements and also provide staff with a greater insight into the influence of human factors on patient outcomes.

Two half day sessions were held two months apart in September and November 2021 with 27 and 28 attendees respectively. The participants included were anaesthetic operating department practitioners, scrub practitioners, recovery practitioners, clinical support workers and novice anaesthetic trainees. The faculty consisted of an anaesthetic consultant, simulation fellow and two clinical skills staff trained in human factors debrief and feedback. The simulation took place within the main theatre suite using a high-fidelity simulation mannequin (SimMan3G). The scenarios were intraoperative anaphylaxis, can't intubate/ can't oxygenate, massive haemorrhage and local anaesthetic systemic toxicity. The candidates were asked to complete a pre and post questionnaire which consisted of six questions on a Likert scale assessing non-technical skills followed by factual short answer questions about the clinical scenario. This questionnaire was then re-sent to the candidates one month later to assess retention.

There was a significant improvement in the Likert scores between the pre and post questionnaire. However this betterment was lost at one month follow up with all scores close to prequestionnaire level. There was an amelioration in the factual question scores between pre and post questionnaires, however at one month follow up approximately 50% of the questions were scored close to prequestionnaire levels. The feedback for the sessions was grossly positive with many attendees asking for further and more frequent sessions. They also commented on how they had not recognised the influence of the non-technical skills upon a clinical scenario until it was discussed at debrief.

The results indicate that the sessions had a beneficial impact on the candidates' non-technical skills as well improving the knowledge base with regards to local and national management protocols. These benefits appear to be waning with time and this demonstrates the requirement for regular training to ensure skill and knowledge sets are maintained. I have understood the importance of regular simulation training in emergency scenarios which we rarely encounter clinically. The training provided here has highlighted how most candidates were unaware of how influential human factors can be on the outcome of a clinical scenario. This training has allowed me to take forward the non-technical skills I have been teaching and apply them myself in clinical scenarios. I am much more acutely vigilant of behaviours such as team working, communication and leadership which have an important bearing on patient outcomes.

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Implementing a New Teaching Session in a Final FRCA Preparation Course

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The final FRCA structured oral examination is an important milestone in the life of any anaesthetic trainee. It marks the end of a long line of exams and prepares the trainee for independent practice as a consultant. While the candidates have exhibited their grasp of the knowledge domain by passing the written component of the examination, the viva exam is a test of application of the knowledge, understanding, and decision making in clinical anaesthesia. Very often the chairman's report published after the examination results reiterates the need for a clear coherent answer and emphasises the need to practice speaking out the answers. Candidates often use exam revision courses to help simulate the exam conditions in preparation for the exam.

As a teaching fellow, I was involved in organising and conducting the Final FRCA SOE revision course. Drawing from my own experience of doing these exams, I identified the need to teach the candidates a method to approach the long case and to use the ten-minute preparation time efficiently. We conducted a pre-course survey to identify the felt need for this session and asked candidates if they had a method to approach a long case and how confident they felt using the allocated preparation time. Following an overwhelming positive response (94% of candidates requested a teaching session), we allocated a 30 minute session during the revision course to systematically teach candidates a way to approach the long case and prepare for the viva.

The session included an interactive lecture followed by the practical application of the learning points by preparing for a long case vignette that was handed to them. The candidates went through the case and identified findings, prepared for potential questions which was discussed, and they were provided with tips to hone their viva technique. We collected feedback at the end of the session. It was largely positive and there was a significant improvement in the confidence scale to approaching a long and short case as seen in the following figures.

Fig 1: Pre-course rating of confidence in using the long case preparation time
(0 being no confidence at all and 5 being highly confident)

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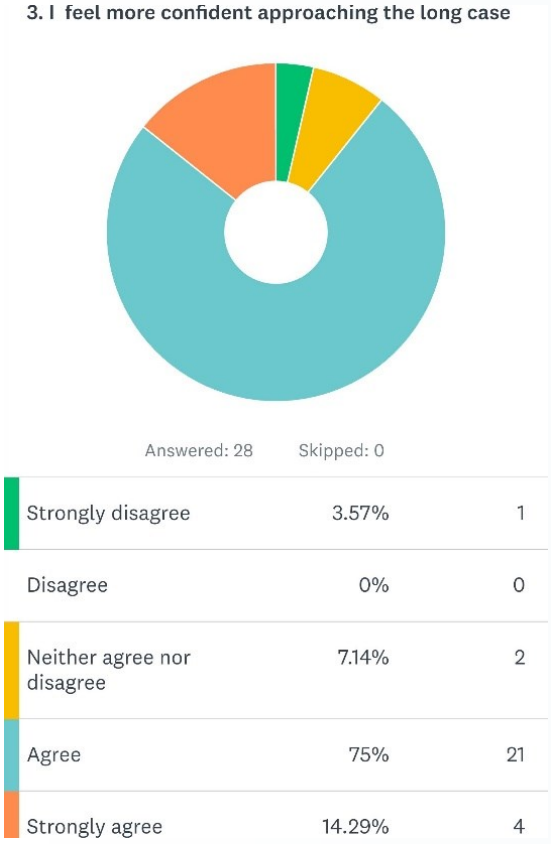

Fig 2: Post session confidence rating

As shown in the Fig.2, 75% candidates agreed that the session improved their confidence in approaching the long case in the exam. Based on the feedback we received we plan to include this session in future courses and will seek to constantly adapt the teaching session to best suit the need of candidates.

In conclusion, exam preparation courses need to be versatile in identifying and catering to the needs of the candidates attending such courses. Focussed teaching of skills and practical guidance will enable candidates to benefit immensely from such courses and improve the quality of the course, in turn setting the candidates up for success in the exams.

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Sim Training—Venturing outside theatres...

Dr Maheeka Nirmalee Rajamuni
Dr Nilmini Kaushalya Manawaduge
Trust Doctors, Leeds Teaching Hospitals NHS Trust

Leeds Teaching Hospitals NHS trust is a tertiary care centre serving specialist services for patients across Yorkshire. The cardio-respiratory clinical service unit is based at Leeds General Infirmary. The cardiac sonography unit is a busy one which provides the services of echocardiography, dobutamine stress echo, and pulmonary function tests.

There had been a few episodes of severe anaphylaxis related to use of SonoVue Contrast. This is a second-generation contrast agent that uses sulphur hexafluoride microbubbles for contrast-enhanced ultrasound imaging in adults. This is used to gain superior visualization of cardiac chambers.

When an anaesthetic colleague approached us about organising a simulation training session on managing anaphylaxis our thoughts were mixed. This certainly was a golden opportunity for teaching and training. However, this was a team that was unfamiliar to us. We were not sure about the facilities available, and the expectations from the session was not very clear. It also did not feel realistic to teach advanced anaphylaxis management treatment in this setting.

How we approached this

We liaised with Shehan, one of the highly specialised cardiac physiologists, and ascertained the objectives of the training session. We only had an afternoon time slot, which was the dedicated time for departmental audit. Having visited the unit beforehand, got an idea of the space available. Shehan arranged a high fidelity sim man and programmed the data according to the planned scenario. We identified a place suited for a brief presentation, and decided to use the cardiac sonography (DSE– dobutamine stress echo) room for the sim session giving the scenario a realistic feel.

We prepared pre and post course questionnaires, and a sim scenario reflecting the usual case of the unit. We only focused this on the initial management and maintaining patient stability till help arrives from the crash team.

We commenced the session with a brief presentation based on identification and management as per 2021 anaphylaxis management guideline. We also included a section on local investigation process to be followed in cases of anaphylaxis.

Positive reception

We had 16 participants, and it was a great experience to see the enthusiasm. We commenced the simulation with a demonstration by ourselves, and as time permitted did two sim sessions with the participants. All the participants engaged very well with during the scenario and this was a truly refreshing teaching experience for us.

The feedback from the session was positive and very appreciative of our efforts.

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Future work
As we identified during this session, this unit is only supplied with 0.3 ml adrenaline auto injectors and this creates a contrast with the current guidance which recommends 0.5ml IM injections. This was due to unavailability of 0.5 mg adrenaline autoinjectors within the trust currently, the pharmacy has arranged to this interim measure.

We escalated the identified concerns to the head of the cardiac physiology unit thereby to the chief pharmacist to expedite the availability of proper adult dose adrenaline auto injectors to the department.

At the end of the day, we also felt far more confident and willing to take simulation beyond the theatres again.

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ACCS ARCP Year 1—a Personal View

Dr Paige Roberts
ACCS Anaesthetics Year 2
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With guidance from:
Dr Sue Walwyn
Yorkshire and the Humber School of Anaesthesia
Regional Advisor

ACCS anaesthetics changed to a new curriculum in 2021 and now consists of a 4-year training programme. The first 2 years consist of 6 months in each of acute medicine (AM), emergency medicine (EM), anaesthetics and intensive care. The final 2 years is spent in anaesthetics. The new curriculum moved towards formative assessments, panel-based judgements and introduced entrustment levels (supervision levels) which are found in the anaesthetic curriculum.

Entrustment levels range from 1 (direct supervision/ involvement) to 4 (no supervisor involvement). Assessors are asked to assign the trainee an entrustment level according to the level of supervisory oversight they would feel comfortable with, when the trainee is performing a procedure or managing a particular situation. You often need to specify this to your supervisor, and explain that it is not supposed to represent the level of supervision provided, but what they would be comfortable with if you were to do this again in the same circumstances. A good tip would be to start getting supervised learning events (SLEs) signed early, even if it means lots of level 1s, because as you progress your entrustment level will progress too, and this is an easy way to demonstrate progression to your educational supervisor (ES).

During CT1, you should try to add evidence to as many of the learning outcomes (LOs) as you can linking them to as many capabilities as possible. By the end of CT1 you will be aiming to complete LO 1, 2 and 4, which is done by sending a HALO to your ES who will sign it off on the basis of key capability achievement and general progression.

The lifelong learning platform (LLP) for ACCS can be found under stage 1 and looks confusing. You will see all the LOs as well as all the HALOs for the anaesthetic curriculum on the same page. For year 1 annual review of competence progression (ARCP) you will only need to concentrate on the LOs, but if you are able to do any SLEs for the sedation HALO, grab the opportunity.

The logbook can be used in year 1 and evidenced for the ARCP, but it is no longer required to see a specific number of cases and it would be worth discussing this aspect with your ES at the beginning of the year. You will need to meet and evidence your meetings with your ES, and you will need to have at least three documented meetings for the year.

LO 1 and 2 are easily completed during CT1, just make sure to read them through as there are some more niche points, for example awareness of needs of vulnerable adults.

LO 4 should be completed by the end of your EM placement, it involves very specific key capabilities such as removing foreign bodies from eye or ear which will be quite difficult to get elsewhere. Have a look at this at the beginning and look out for the specifics.

You should also try to make a start with LO 5 for your ARCP, as this has a lot of the procedures, again some of them are quite EM specific like fracture/dislocation manipulation. The rest of them can also be done in CT2 so don't worry about completing this in CT1. The procedures have associated entrustment levels, so ensure that everyone understands this when completing the SLE. If they are entrustment level 1 you can sign this off by doing simulation or, as in the case of open chest drain, ATLS.

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For LO 3, 6, 9, 10 and 11 you should try and add to these over the year with each assessment you do, but don't worry about completing them in CT1. You need a multisource feedback (MSF) for both placements in CT1, this can be quite hard in EM where you may not frequently work with the same nurses or healthcare assistants. A good tip would be to collect emails as you work. Then towards the end, you can cherry pick from all of these people and send invites to the ones you have worked with the most and will give you the most helpful feedback. The minimum requirement is one MSF per year and make sure that you start it early enough to allow for the delays.

For EM you need a faculty educational governance statement (FEG) and for AM a multi-consultant report (MCR) these are both MSFs but just for consultants. Your supervisor usually needs to send these out, but it can be helpful to have an idea of who you want it sent to, and even better if you have their emails prepared.

Year 1 ARCPs are much less stressful than they used to be. Gone are the multiple competencies and the large number of tick boxes. However, the new curriculum, and by extension the ARCP, are designed to assess your overall progress as a learner. Try not to leave all the LOs until the second year ARCP and make sure that you think about your overall professional progress, and the importance of evidencing the non clinical LOs throughout the ACCS curriculum.

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A Trainee's Guide to the ARCP for ACCS Year 2

Dr Nick Wroe
ACCS Anaesthetics Year 3
Mid Yorkshire Hospitals Trust

With guidance from:
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Yorkshire and the Humber School of Anaesthesia
Regional Advisor

The hardest thing in ACCS CT2 is working out what the requirements are. While the new curriculum is less burdensome in many ways, there isn't an easy ARCP 'tick list' any more.

You need a holistic assessment of learning outcomes (HALO) signed by your educational supervisor (ES) for each of the "ACCS" labelled learning outcomes LO1-11. Many of the ACCS outcomes are duplicated in the anaesthetic curriculum with similar names e.g. "ACCS LO9 support, supervise and educate" compared to "education and training". You can link your assessments or activity relating to teaching to both of these, saving you time and making it easier to get them both signed off. If you get enough assessments linked to the anaesthetic curriculum you will have a much easier time next year. By the end of stage 1 (end of ACCS CT4) you will get the rest of the curriculum HALOs and make the 'donut' go green.

You also need EPA 1 and 2 (the initial assessment of competence (IAC), and a HALO for sedation. The IAC is well covered by the EPA 1 and 2 workbook. My only advice here would be make use of the suggested topics in the 'fish bone diagram' on page 8 as a theme for your assessments – and use the lifelong learning platform (LLP) quick sign feature to get them approved on the day, so you're not chasing consultants around.

Trainee exposure to sedation in ACCS CT2 can be tricky – often it comes in unusual places such as a cardioversion overnight in the emergency department when covering intensive care with a registrar, a PEG list in theatres, or dressing changes for burns.

If you're not sure what is required of you, check with your college tutors or training programme director (TPD) early as it's much harder to sort these things last minute. Generally speaking you need a multi-trainer report (MTR, like a consultant MSF) to get a HALO signed off for a clinical module such as the IAC, or sedation. You will also need one MSF per year and a clinical supervisor sign off for ITU.

You need to keep a logbook of anaesthetic cases (you can do this on LLP). Start this from day 1 in theatres and try to keep on top of it prospectively e.g. in between cases, when you are sent for a coffee break, or on the walk to the car after your shift. Having an up to date logbook means the ARCP panel can see all the good work you do, and the range of experience you have gained.

The use of an ARCP decision aide can help in your preparation (https://www.rcoa.ac.uk/sites/default/files/documents/2021-04/ACCS%20ARCP%202021-2%20Decision%20Aid.pdf) but the most important document you need to generate prior with your educational supervisor (ES) is the educational supervisor's structural report (ESSR). Remember to link all the evidence to the ESSR, so that the panel are able to see this, as they have limited access to your information on the LLP. The admin will need a Form R covering all aspects of your practice, so link this too.

Another good tip for ARCP is to make sure all the good things you do make it onto LLP, whether this is regional teaching, a course, e-learning module, teaching medical students, presentations or exams. Every time you are sent a certificate, put it on LLP, you have done the work, so absolutely deserve to link it to the curriculum and use it to get things signed off.

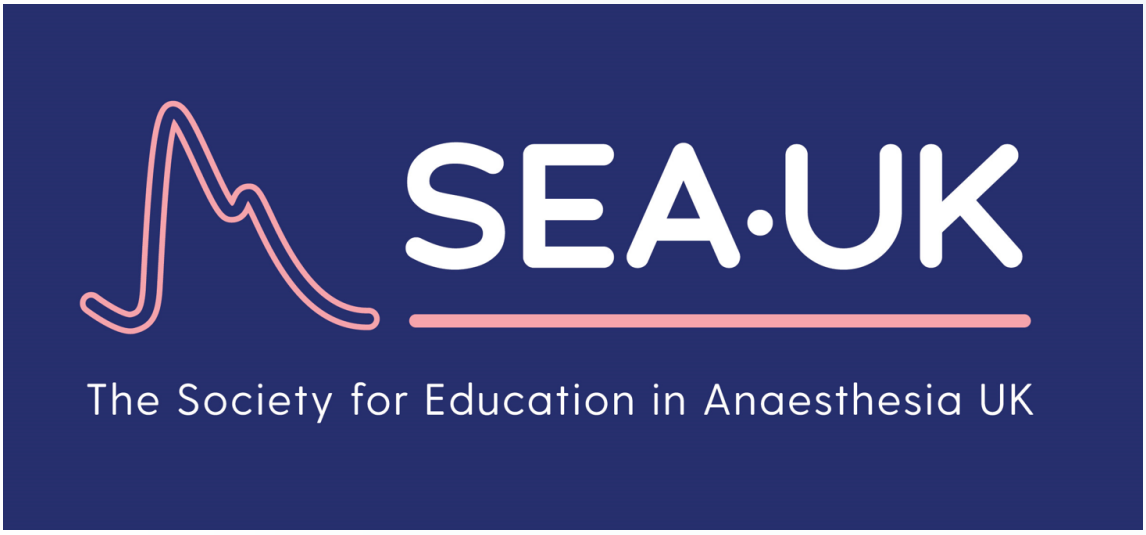
ARCP is essentially convincing people you have never met, that you are a "good" trainee. The more evidence there is and the better it is linked to the curriculum, the better. Make full use of study leave so you don't spend all your free time on portfolio, work or quality improvement projects.

Writing a reflection on how your skills are progressing e.g. 3 to 6 months in is useful for you to see how far you have come (which is good for morale) and for trainers and ARCP panel to demonstrate progression.

SEAUK

Update on the new SEA-UK Logo

We have made progress with designing the logo and we thank Rachel for her great work. The final version will be released at the AGM in May 2023. This is the final draft version and we would invite comments to be sent to the Secretary (secretary@seauk.org) or President (president@seauk.org).



SEAUK

SEA-UK Educational Grants

How to apply

Application: Use 1-inch margins max, strictly in 11 point Arial script, single spaced, submitted as a word document or pdf file.

Page 1: Single page detailing title of project, applicants (names, positions, qualifications, contact numbers and emails).

Page 2: The body of application must be no longer 500 words. This should include details of the project undertaken and the costings involved.

Please send applications to: **administrator@seauk. org**.

We are pleased to invite members to apply for one of 4 x £500 educational grants.

Criteria: SEA-UK grants can be used towards any prospective educational research and quality improvement activities that falls within the broad interest of education in anaesthesia.

Funding may be sought for:

- Travel to undertake an educational activity that is generally not available in the region.
- Travel to present the original research activity
- Projects that develop education for anaesthetists which strive for excellence above and beyond current available activities
- Necessary fees for access to data or to complete the project which must be justified

Applicant must already be a SEA-UK member to apply (or join at the time of submission).

Specific Exclusions: No retrospective funding can be given. We cannot subsidise OOPE. We cannot support teaching on courses and postgraduate courses.

All publications must acknowledge SEA-UK as a funder. On completion of the activity a report, including an 800-word article for the newsletter, is expected. You may be invited to speak at our ASM.

SEAUK

SEA-UK Membership

Membership fees:

Full membership is £25 per annum paid by direct debit

How to join:

Online form: https://www.seauk.org/join-seauk
or download and fill in the GoCardless direct debit form, available at www.seauk.org

Please send to:

Cath Smith
SEA-UK Administrator,
PGME,
Rotherham NHS Foundation Trust,
Moorgate Road,
Rotherham
S60 2UD

administrator@seauk.org

Benefits of joining

- Receive updates on latest developments in education
- Bi-annual newsletter
- Free webinars
- CPD accredited meetings and workshops
- Learn from others in our educational forums
- Updates regarding curriculum changes for trainees and trainers
- Build your portfolio
- National influence within anaesthetic education
- Opportunities for website development
- Discounted entry to ASM