Anaesthesia News

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Association of Anaesthetists

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Welcome

I am delighted to welcome you to this special trainee issue of *Anaesthesia News*. Trainees have always been valued in anaesthesia, and this is reflected by the Association of Anaesthetists. The Association's Trainee Committee has been in existence for 52 years and we are proud to have an annual special issue of *Anaesthesia News* dedicated to topical trainee issues. However, I think this issue will appeal to anaesthetists of all grades and I urge you to have a flick through!

The theme of this year's issue is 'obscure, but essential trainee topics'. I proposed this theme to the Trainee Committee in October 2018, and am yet to come up with something snappier! Articles have been commissioned specifically to deal with topics that are often not explained well elsewhere yet are vital snippets of knowledge. Having recently 'CCT-ed' and been through the consultant interview process myself, I know post-fellowship trainees will be thinking about the next hurdle in their careers. I would like to thank Eoin Kelleher (Trainee Committee Elected Member) for illustrating this on the front cover of this issue.

Katy Miller talks openly about the choices available upon completion of training in her article titled 'ST7 year and beyond…'. Helgi Johannsson and Stephanie Cattlin dispel the myths surrounding consultant interviews in their respective articles from a clinical director's and a new consultant's perspective. Julian Berlet talks frankly about consultant pre-interview visits and how to put yourself in the best position of securing your desired consultant post. The working life of a consultant is different to that of a trainee. I envisage the articles on 'Consultant job plans – the basics' and 'Consultant appraisal – a clinical director's perspective', written by David Ray and Nick Parry respectively, would be not only essential, but beneficial to consultants new and also those maybe not so new…!

Doctors need help and support during difficult times, and through transitions points in their careers. Peter Rogers and Elisabeth Wilson talk about an innovative, but simple initiative to support junior doctors in their article 'Peer support in hospitals'. In the article 'Consultant mentorship' Sally Millett describes the benefits of mentoring, something which is strongly supported by the Association.

Finally, this is the last of my four years on the Trainee Committee. I am privileged to have been trainee issue editor the last three trainee issues of *Anaesthesia News*. I hope you enjoy reading this bumper issue of *Anaesthesia News* as much as I have!

Satinder Dalay
Elected Member, Trainee Committee

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Peer support in hospitals

Training in any field of medicine causes stress from a number of areas, whether through exams, emotionally or challenging cases, frequently moving around the country, or being separated from close friends and family. You are doing a job that you may not feel comfortable with, and as soon as you find your feet you move specialty, role or trust.

As a group of juniors, we felt that we could do more to support our colleagues and each other. We have organised a time for junior doctors from across the hospital to meet and share experiences and discuss problems. The aim of the monthly meetings is to provide an informal setting for support, acknowledgement and reassurance, as well as share ideas and provide a space for reflection. Additionally, we aim to signpost sources of support such as a supervisor, counsellor or general practitioner. The basic starting point for the meetings is that quite often the things that cause stress and anxiety are common to us all. The uncertainty inherent to our job and the feeling that we can't live up to what's expected of us can weigh heavily. It's easy to feel that everyone else is managing brilliantly and excelling, when in reality they are as stressed as you are and aren't quite sure how you are doing it all so well.

The meetings are open to all junior doctors and held at lunchtime to make attendance easier. We introduce the purpose of the meeting as a reminder for people who have been before and as an explanation to new attendees; we also remind people to respect each other's confidentiality (but adding that we will break confidence if we feel anyone is at risk of coming to harm). People are then free to talk about things that are causing them stress and we discuss the surrounding points. Practical advice can be offered by anyone, as none of us are experts, and side discussions are encouraged as people are likely to feel more comfortable talking in smaller groups. Sources of help are signposted and coffee is drunk. Sometimes the conversation is serious throughout and at other times less so. Feedback from attendees has been positive over the course of a year and has encouraged us to continue with the project.

The qualitative feedback from junior doctors attending the sessions includes:
"Good to hear other people's experiences"
"Relieves stress"
"Interesting discussions."

We know we aren't the only people who have set up meetings like this. The Association of Anaesthetists Coffee and a Gas is based on the same concept, but why stop with anaesthetists? Meeting up with colleagues from around the hospital can give a different perspective and helps tackle isolation. This 'all juniors welcome' approach can also help increase cohesion between teams, which in turn must be good for patients.

At the end of July 2017, a colleague one of us knew well took his own life while 'on shift'. Within the last two years we have become aware of similar tragedies in every other trust in the region, including where one of us currently works in North Devon. The majority of us will have been affected by suicide, whether it is a friend, colleague or acquaintance. It happens to good people too often for us to stand back and remain inactive.

One year on from starting these meetings they are still well attended, and feedback has been very positive. These groups take only a small amount of effort to organise and a little more effort to promote, but all in all are easy to set up. They can reach a lot of people directly and hopefully help those attending to find like-minded people to talk to or provide signposting for more formal help.

Peter Rogers
Anaesthetic ACCS CT3
North Devon District Hospital

Elisabeth Wilson
CMT CT1
Musgrove Park Hospital

Some tips:

Run the sessions as a group; it's difficult to attend sessions regularly as a single person with rota constraints

Recruit from all over the hospital for different opinions

Promote sessions via the medical education centre, the mess and word of mouth

Encourage people to feel free to submit subjects/themes they'd like to discuss ahead of time if they would like things raised anonymously

Choose a private room that is accessible to all

Set a regular time to hold the meetings so people know when to expect them

Establish confidentiality limits/ rules at the start of the sessions

Use frequent signposting and provide leaflets/information for local counselling/deanery support sources

Provide lots of coffee and cake (our Trust supplies it)!

Evelyn Baker Award

An award recognising the 'unsung heroes' of anaesthetic departments.

The Evelyn Baker award is made for outstanding competence in all areas of anaesthetic practice: clinical excellence, teaching and training and supporting colleagues. The Award recognises the 'unsung heroes' of anaesthetic departments.

Nominees are often described as the unspoken backbone of the department and the 'go to' person for clinical or other advice. Citations accompanying nominations for this award should describe how the individual being nominated demonstrates those characteristics and traits that set them apart from others. The defining characteristics of clinical excellence are technical proficiency, consistently reliable clinical judgement and wisdom, and skill in communicating with patients, their relatives and colleagues. The ability to train and enthuse trainee colleagues is seen as an integral part of communication skill, extending beyond formal teaching of academic presentation. Supporting colleagues and co-workers is a valued part of clinical practice and is recognised by this award.

The award was instigated by Dr Margaret Branthwaite in 1998, dedicated to the memory of one of her former patients at the Royal Brompton Hospital.

Nominations are now invited for the award, which will be presented in January at the Winter Scientific Meeting 2020 in London. Members of the Association can nominate any practising anaesthetist who is also a member of the Association. Nominees should normally still be in clinical practice. The award is unlikely to be given to someone in their first ten years as a consultant or SAS doctor, and the nominee should not be in possession of a National Clinical Excellence Award. Nominations should include an indication that the nominee has broad support within their department.

Last year the award was won by Dr Ian Appadurai (Cardiff). Details of previous winners and further information can be found on the website **www.aagbi.org/about-us/awards/evelyn-baker-medal**

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The nomination, accompanied by a citation of up to 1000 words, should be sent to the Honorary Secretary at **HonSecretary@aagbi.org** by **17:00 on 31 July 2019**.

On-table cardiac arrest – a CT1's perspective

It is a Friday afternoon in what has been a busy week for a novice trainee who is still climbing up the steep learning curve of the job and every day, without fail, is a learning day. In preparation for solo on-call duties we have been carrying the on-call bleep 'in hours' with more senior support who can attend emergencies with us if required. Earlier in the week I asked the specialist registrar for help in the Emergency Department with a patient who had collapsed, and I was taught about the principles of neuro-protective anaesthesia. A few days later I saw the patient's organs donated. That surreal moment of disconnection will stay with me. Earlier that morning I had assisted in an anaesthetic for a patient with a severely stenosed heart valve who nearly arrested in the anaesthetic room and required adrenaline to stabilize them. I spent the end of my morning zipping back and forth to ITU with gas syringes.

Over lunch I talked to my educational supervisor about this and we agreed my week has been surreal in places, with a multitude of learning points to take from these experiences. My brain feels fried and I haven't assembled my thoughts about the organ donation. However, I have a straightforward general surgery list to carry me through the afternoon and then I'm going home for the weekend. Later that afternoon we are finishing up a hernia repair without any hiccups. I can't even remember what procedure the next patient was due to undergo, all I can remember is my brain being slow when the alarm goes off. It was 'the alarm'. My theatre is between cases, so the consultant and I are free to go, flashing lights guiding us to the theatre with the emergency. It all happened very quickly. All the people in surgical gowns backed away, trays are pulled out and the drapes were ripped back. It felt unnatural. The patient was the wrong colour and chest compressions were started. There was a clear history of what happened: it was expected to be a straightforward case; they were otherwise fit and well; and, this sort of cardiovascular collapse was not on the cards. My consultant did the compressions as I stuck the defibrillator pads onto the patient around his hands. I can feel the femoral pulse under my finger in time with the chest compressions. It was an easy stab and I filled the bottles and as I headed across to ITU a flurry of people run past me including my educational supervisor. They said something to me, but I didn't catch it. Something encouraging? A question about the case? All I can replied was: "I'm going to get the gas."

The ITU trainee said "Another gas? You already needed three this morning." It was said in jest, but I must have looked anxious because their expression is a look of sincere concern. They got a one-sentence, garbled handover and those who were free went to help. I returned to the arrest with the ITU trainee. As we entered the theatre more adrenaline was given; everybody was un-scrubbed, and the wounds were closed. People queued up in an orderly fashion to do the compressions. Somebody at the head end called instructions, somebody on the defibrillator called timings and there was a frantic scribe. We thrombolysed; the most likely 'T' of the situation was 'thrombosis'. The ITU trainee promptly turned back around and took me with them. I was going to learn where the alteplase was kept along with the dosing regimen. Yet another learning opportunity.

There is some irony in emergency drugs that we rarely use being ever so slightly awkward to draw up. On our return the adrenaline pile was bigger, and bicarbonate was being given; the compressions were good quality and everybody was encouraging each other. All elective theatres have stopped and everybody was here. The scrub staff asked why we had to continue CPR for so long. I explained that we needed to "give the clot-busting drug a chance to bust a possible clot". As I was

going in and out of theatre so much I had only been getting short clips of the situation as it evolved. Later on I would think about how everything had happened as it should; there was leadership, there was a plan and we were working as a team. The more senior staff from every faction, though they looked a little on edge, forced a calm atmosphere – a quiet confidence which in turn spreads to the rest of us.

As I waited my turn for compressions and I had a feeling of nearing my limit. The combination of cognitive demand, stress and emotion was reaching maximum capacity. I didn't suddenly break down weeping or screaming, I just knew that I wouldn't be as good or potentially as safe at my job as I could be. As time passes in medicine, you accrue experience and it takes more and more stress to have that feeling of reaching maximum cognitive capacity - but it will happen. Perhaps not as often as in your junior years, but it does happen. After the week I had experienced, I wanted to stop. As I approached the front of the chest compression line my educational supervisor made eye contact, and they saw it too. They told me to leave; I did not protest. I left theatre and had a cup of tea. I spoke to the specialist registrar coming on duty for the evening and tried to get them up to speed. I felt bad for leaving my colleagues, but I knew there were plenty of people there and the patient was having the best care possible.

That evening I was heading home to visit my family. The drive home gave me time to dissect my week. I have been watching my seniors practice for the viva and follow suit: classify and categorize, or die. I looked at objective learning points: physiology, pharmacology, physics and non-technical factors. As the cases become increasingly complex it gets more complicated and subjective but ultimately I feel like all the training we have for when things go wrong, works. A sense of urgency rather than panic, hoping for the best possible outcomes while making plans for the worst-case scenario, and everything in between. On Monday night I came in for my shift. So, I missed the debrief in the morning. The patient sadly died; they had a ROSC for a time and the family were able to come into theatre to say goodbye. The surgeon cried. Everything that could have been done was done. There was no fault made regarding the resuscitation attempt.

A mini-debrief just for me

The following morning as I finished my night shift, we had a junior's meeting for sharing learning experiences and drinking tea. The consultant leading it got me to talk through what happened. A mini-debrief just for me and I couldn't be more grateful. Somebody to confirm it really was as stressful as you remember it - you are experiencing something like a normal human being. It should feel strange to rip drapes off people and feel disheartened when you have done everything you can and nothing seems to change.

From a CT1's perspective I was glad my seniors let me talk as much as I needed and provided a balanced debrief. Discussing treatment and management is just as important as acknowledging the emotional side of an emergency scenario. I don't want to be sheltered or coddled: that won't make me a good doctor. And yes, it is helpful when seniors question our clinical understanding, as much as we may protest. This was a tragic story at the end of a challenging week for me as a junior. However, I want to feel capable about it when there is a next time, so I know am doing right by the patient. As a CT1 I don't know how often to expect certain scenarios, should they happen once a month, once a year or once in a career? After this scenario, I don't think this is an area where anaesthetists should ever allow themselves to become desensitised.

Catriona Spiers
CT1 Anaesthetics
South Wales

Need some help?

This sounds like an incredibly challenging week for an anaesthetist of any grade, let alone a novice. It seems your department have done a great job in offering informal support to you – this is essential. A well-structured de-brief with others present during a specific incident can be reassuring but, due to shift working, this may occur at times when not all staff can attend. As trainees we should therefore have numerous people we can turn to in times of need, which may vary depending on the situation.

Educational Supervisors are often an excellent first port of call; there should be an existing relationship here. College Tutors are likely to have extensive experience of helping trainees and may also offer assistance. Other trainees can provide great support in difficult circumstances and may feel more approachable. In our experience of challenging situations, we've turned to consultants and colleagues with whom we've had a close relationship, and despite not having a specific pastoral role, found them incredibly supportive. It is unlikely consultants will have made it through training without experiencing significant events in their work that have had an effect on them and they can offer vital perspective. Outside work, letting friends and family know that that you're having a challenging time can help them to help you.

Sometimes situations we are involved in can leave us emotionally stressed, anxious or depressed. Informal chats with colleagues may not be enough; friends and family may struggle, and we may need professional support. Beyond the anaesthetic department, the hospital occupational health team have a responsibility for the health and wellbeing of staff and should be able to arrange assessment and counselling sessions if needed. Depending on the arrangement in your Deanery, this may also be available through your Lead Employer Trust. We should all be registered with a GP who can provide objective advice – don't forget them. There is also the BMA, who offer excellent 24/7 counselling services. They have a peer support network and can put you in touch with other doctors experienced in supporting the emotional needs of doctors and medical students. Peer support is also available via the Doctors' Support Network. DocHealth is a confidential, not-for-profit, psychotherapeutic consultation service for all doctors and up to six sessions can be booked, although there may be a fee. Trainees in England can contact the Practitioner Health Programme, a free and confidential NHS service for doctors and dentists with issues relating to a mental health concern or addiction problem. A social media initiative worth noting is the 'Tea and Empathy' group on Facebook and Twitter, a national peer support network for NHS staff. Many of these support options can be found on the Association's wellbeing page and are listed in the box.

Life as an anaesthetist can be varied, hectic and incredibly rewarding. It can also be stressful and heart-breaking. Our patients and their families are often experiencing one of the worst days of their lives and it is only natural that we take some of that on ourselves. As clinicians we rarely talk openly about the emotional toll of our work. The Association's #coffeeandagas initiative was launched to encourage informal chats between staff. Another option could be a hospital Schwartz Round. These are evidence-based forums for hospital staff from all backgrounds to gather to talk about the emotional and social challenges of caring for patients, and offer a safe and neutral place to share experiences – it's worth looking into whether your Trust offers them, as evidence suggests that those who attend regularly feel less stressed and isolated at work. Ultimately, whatever your week may throw at you, we're all working in this environment together and better relationships mean better support in times of challenge. It is important we look out for ourselves and each other, and remember that it's ok to not be ok.

Karen Stacey, ST7 London
Lucy Powell, ST6 Newcastle
Trainee Committee, Association of Anaesthetists

Useful links

https://www.aagbi.org/professionals/wellbeing/do-you-need-help

https://www.bma.org.uk/advice/work-life-support/your-wellbeing/counselling-and-peer-support

https://www.dsn.org.uk/

https://www.bma.org.uk/advice/work-life-support/your-wellbeing/dochealth

https://php.nhs.uk/

Twitter @Tea_EmpathyNHS

https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/

Conversations are important to help us share our experiences and reduce stress levels. Take a moment to catch up with colleagues over a coffee. Find out more at:

www.aagbi.org/coffee-and-gas

Consultant mentorship

Mentoring is the practice of facilitating a person's development. 'To help and support people to manage their own learning in order to maximize their potential, develop their skills, improve their performance, and become the person they want to be' (Parlsoe; [1]).

Mentoring tends to involve an experienced individual using their greater knowledge of the work or workplace to support the development of an inexperienced colleague. However, it is not directive; at its best it takes a coaching approach where the mentor helps the mentee to find his or her own path and solutions. It has been described as helping without telling. A mentor can provide support, direction and an objective view on how the mentee can develop and progress in their working environment.

Who needs mentoring?

Anyone and everyone at some time in their careers could benefit from a mentor. This is particularly the case around times of transition and change, for example starting a new consultant post or returning to work after a career break. Mentoring is not just for doctors at a crisis point, it can also be used to further challenge and develop the most able of people. The GMC advocates mentoring for doctors in enabling the delivery of safe and effective care when taking on a new role. In Leadership and Management for all Doctors it states: 'you should be willing to take part in a mentoring scheme offered by your employer' [2].

What does the mentee get out of the relationship?

- help with achieving outcomes that the mentee cares about;
- help in exploring weaknesses and gaps in their experience and knowledge;
- exploring understanding, perspectives, attitudes, beliefs and thinking styles through a supportive relationship;
- an opportunity to talk through issues requiring a decision or action;
- some judicious challenge and support around facing difficult issues and developing self-awareness;
- assistance with reflection leading to personal and professional growth.

For doctors in training the Local Education and Training Boards or Deaneries should provide, or be able to provide access to mentoring. For new consultants many employees' organisations will have a mentoring scheme in place. To try out mentoring there are free taster sessions available at the Association's national meetings including the Trainee Conference in July 2019.

What can happen in a mentoring session?

A mentoring meeting is typically a formalised structure of dedicated, private, uninterrupted meeting time. The content is guided by the mentee. A skilled mentor will use a combination of questioning, listening, observation and feedback to create a productive conversation which fosters insight and learning. The mentor encourages the mentee to find their own solutions to move forward. The frequency of meeting is agreed between the mentor and mentee; typically, this takes the form of regular meetings for up to a year for newly appointed consultants.

At the start of the mentoring relationship, the mentee will need to think about what the gap is that he or she would like mentoring to fill. It might be around:

- integrating into the team;
- understanding how to take on a new role or project;
- leadership;
- help with managing working relationships;
- balancing responsibilities inside and outside work.

It is useful to set some goals as the mentor and mentee begin to work together.

Sally Millett
Consultant Anaesthetist
Worcestershire Acute Hospitals NHS Trust

References

1. Connor M, Pokora J. Coaching and mentoring at work: developing effective practice. Open University Press; 2007
2. General Medical Council. Leadership and Management for all Doctors. London; GMC; 2012 (https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/leadership-and-management-for-all-doctors)

Overcoming taxing issues with taxis

Most anaesthetists at some point in their career will have found themselves after a transfer stood outside an unfamiliar hospital, in the cold, with a mountain of equipment waiting for a taxi to take them back to their usual place of work. The inter-hospital transfer of critically ill patients more often than not falls to trainees. Some critical care networks have developed dedicated transfer services with a specialist transfer team or trolley. This means the ambulance service is obliged to transport the clinical team back to their base hospital. However, in London the demands on the London Ambulance Service mean this return journey is not possible, no matter how hard an anaesthetist might try to charm the paramedics.

The Association's 2009 Interhospital Transfer safety guideline states 'arrangements must be in place to ensure that personnel and equipment can safely and promptly return to base after the transfer' [1]. At our Trust we audited against these guidelines and found 80% of trainees had experienced significant delays, with several waiting up to three hours for a taxi. As these staff were usually part of the on-call team there were important repercussions for the hospital as well as great frustration for the trainees. 'CEPOD cases' were being delayed, cover for emergencies such as cardiac arrests were reduced and, in some cases, daytime elective lists were being cancelled when the on-call consultant had been called in overnight.

The issue it seemed was twofold. Firstly, there were delays just booking a taxi through the Trust's contracted taxi firm. The convoluted process involved the transfer team calling the intensive care nurse in charge, who then spoke with the site manager. The site manager had to sign an authorisation form which was then faxed to hospital security. Hospital security then contacted the taxi booking office to arrange the pick-up. The second issue was that the taxi firm the Trust used frequently did not have taxis regularly available in the vicinity of the hospitals where they were needed. At night sometimes just a single taxi driver would be covering the whole network's activity.

The solution seemed clear to all front-line clinicians. London is not short of taxis. In recent years firms such as Addison Lee and Uber have firmly established themselves across the city, with many more vehicles and far greater coverage than the Trust's taxi firm. When compared with the contracted taxi firm's rates, use of the former was relatively cost neutral, whereas the latter would provide the Trust with a potential cost saving benefit. Trainees could order a taxi using their smart phone and submit their receipt later and claim back the expenses. Several trusts in London already have accounts with these providers. The London Ambulance Service even uses them to transfer patients.

This project quickly gained the backing of the clinical leads and the departmental service manager. However, the Trust's management team were less enthusiastic. Objections were wide ranging. One particularly notable objection was that the Trust couldn't guarantee that other taxi drivers would be trained in safeguarding, moving and handling, or looking after passengers with dementia. Since we were only ever proposing the use of these taxis for staff transport, this did raise some eyebrows. Other objections were more reasoned, for example the insurance arrangements for the equipment that was to be carried.

Potential barriers addressed

The difficulty we encountered was identifying ultimately who had the authority to approve this project. Identifying the hierarchy and management structure was challenging. Emails bounced back and forth between senior managers in the finance, contracts and estates departments, often with very lengthy intervals between replies. There did not seem to be a great deal of interest for the project, nor, as was becoming clear, much understanding about the clinical need either. After several months with little progress, we attended a feedback meeting with the Trust's taxi firm. Getting the various stakeholders in a room together for a meeting achieved far more than months of back-and-forth emails. It meant the project and its motivations could be clearly articulated and the potential barriers addressed.

The Trust's legal team had a number of concerns, ranging from personal liability cover to licensing and criminal record check issues. These are all covered by a Transport for London government license, but it took time to investigate. One of the greatest issues to resolve was whether the Trust's equipment would be insured in the event of an accident. Once it became clear that it wasn't, we made further inquiries. It transpired that it also wasn't covered when using the Trust's contracted taxi firm, and potentially not even when travelling with the ambulance

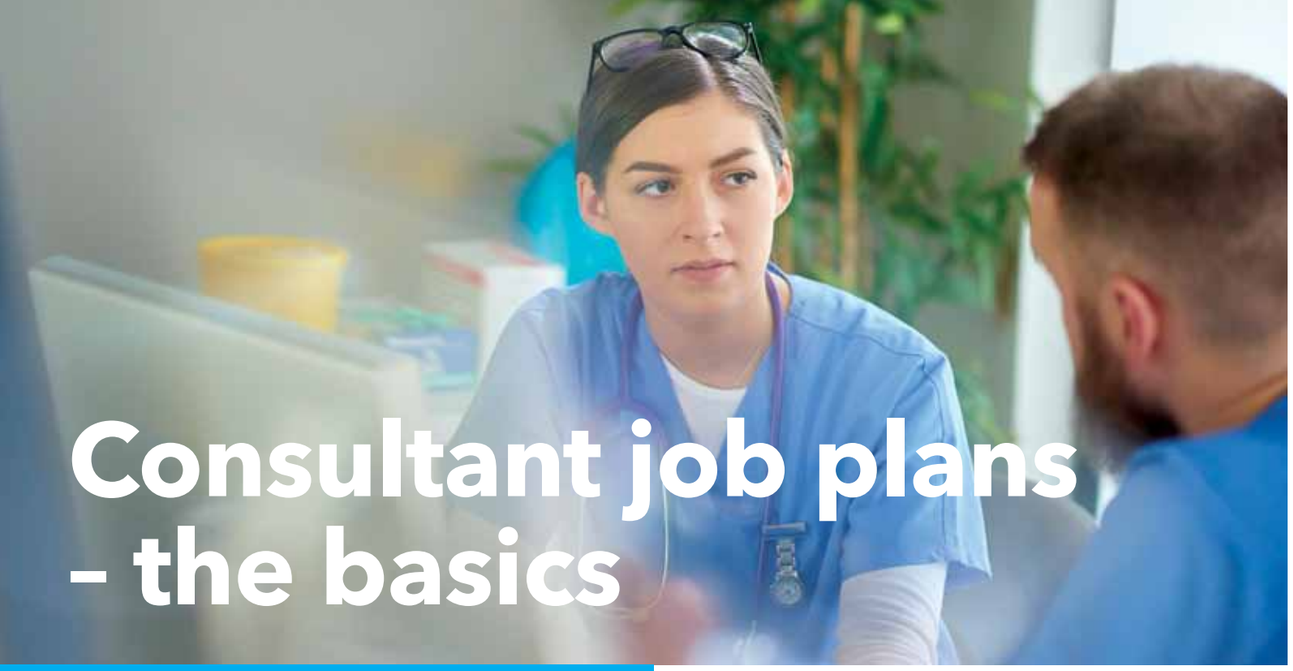
service. We had done a great deal of research into the various legal arguments but couldn't find a member of senior management to hear our case. Momentum faltered and it seemed like the project was doomed. At this point we decided to escalate the issue to the Chief Executive. In a thorough but concise email we explained the background to the project and our proposed solution. In less than 24 hours we had a reply explaining that he had made the necessary enquiries and the project had been approved. Trainees would be allowed to use Uber taxis to get back to work after their transfers.

This quality improvement project took over 18 months to implement. Due to the project's nature, most of the work was done with the departmental service manager rather than through a lead consultant. This was perhaps different to many other quality improvement projects trainees may be involved with. These issues are not unique to London. We hope that others consider implementing such a system at their place of work. We are very happy to share specific learning or answer questions others may have.

Key learning points:

- Consider involving your departmental service manager in quality improvement work. Their support can be invaluable. Try to meet them and other stakeholders face-to-face. More can often be achieved through a meeting than many back-and-forth emails.
- Be persistent. Don't give up at the first hurdle. Where objections are made, try and relate back to the implications they may have for patient care.
- When all else fails, escalate (appropriately). Contacting the Chief Executive seemed like a bold move at the time but achieved more in 24 hours than the previous three months of work.

Chris King
ST4 Anaesthetist
Lewisham and Greenwich NHS Trust



Consultant job plans – the basics

A consultant job plan is an annual, prospective agreement between the employer and the consultant, and should be based around the terms and conditions of the Consultant Contract agreed in 2003 and subsequently updated in England (2018), Scotland (2007), Wales (2011) and Northern Ireland (2013). Broadly speaking, the principles are common in all the home nations although the implementation may differ slightly between countries. The job plan should set out everything that a consultant does in a typical working week, including any private or independent practice, ensuring that no activity is double counted. Specifically it should set out what work is done for the NHS, when and where that work is done, how much time the consultant is expected to be available for work, what flexibility there is around that, what objectives are to be achieved by the consultant and what resources the employer should provide to support these.

The typical full-time consultant job plan is based on working an average of 40 hours per week in England, Scotland and Northern Ireland and is nominally comprised of ten blocks of programmed activities (PAs) of four hours each; in Wales it is based on an average of 37.5 hours per week in blocks of 3-4 hours. PAs are generally classed as those related to direct clinical care (DCC) and those related to supporting professional activities (SPA). In some circumstances other (temporary) PAs may be included for additional programmed activities (APA, or EPA in Scotland), and less commonly for additional NHS (HSC in Northern Ireland) responsibilities or external duties. The job plan should not usually exceed a total of 12 PAs. Annualised job plans may allow working in excess of 12PAs in some weeks as long as the annualised average is no more than 12 per week. Increasingly electronic job plans are being used; these offer increased transparency and avoid double counting of activities, and should follow the principles agreed in the 2003 consultant contract.

DCC PAs include predictable and unpredictable work performed while on call and include activities shown in Box 1 (this list is not exhaustive). SPAs are divided into core activities necessary for CPD, job planning, mandatory training, appraisal and revalidation, and others including research, teaching, and training (Box 2; again this list is not exhaustive). It is very helpful if tariffs are agreed centrally with the employer for involvement in educational and clinical supervision, personal appraisal and appraisal of colleagues, and undergraduate teaching (e.g. educational supervisor 0.25 SPA per week per trainee, appraiser 0.25 SPA per week). The wording in the model consultant contract is that job plans 'will typically include an average of 7.5 PAs per week of direct clinical care and 2.5 PAs of supporting professional activities'. Recently, however, consultant job plans have been produced with a different DCC:SPA split, often 8:2, but sometimes 8.5:1.5 or 9:1. The Academy of Royal Medical Colleges, Association of Anaesthetists, Royal College of Anaesthetists and BMA consider that 1.5 SPA is the minimum required to allow a consultant to keep up to date and undertake mandatory CPD and activities to permit appraisal and revalidation. Where a job plan has fewer than 1.5 SPAs, there should be opportunity for the consultant to make the case for increased SPA recognition at job planning which should occur at least annually (and often within 3-6 months of a consultant's initial appointment). A survey of anaesthetists working in Scotland and appointed within the previous ten years found 74% had 1 or 1.5 SPA at the time of appointment - this dropped to 33% after job plan discussions. Additional or Extra PAs may be agreed for clinical and non-clinical activities. These APAs or EPAs are temporary, should be reviewed annually, and currently are not pensionable.

Additional NHS or HSC responsibilities may also be recognised; these are special responsibilities not undertaken by most consultants and are duties performed on behalf of the employer or government that are beyond the typical range of SPAs. These include medical leadership/clinical director roles, senior roles in governance, lead roles in appraisal, regional adviser, and undergraduate or postgraduate dean roles. External duties may be recognised separately; these are not done directly for the NHS employer but are often in the broader interests of the NHS, and may be related to work for Royal Colleges (and the Association of Anaesthetists), GMC, governmental roles, CQC and involvement in consultant appointment committees.

In addition to PAs, payment (calculated as a percentage of basic salary) is made for on-call availability. The amount ranges from 1% to 8% and depends on the frequency of on-call rota and the typical nature of the response (such as whether immediate return to work is required or not).

Job plans should be reviewed annually – such reviews should encompass the whole range of the consultant's work, including clinical duties and SPA. Further details may be found in the supporting information listed below.

David Ray
Consultant in Anaesthesia and Critical Care
Royal Infirmary of Edinburgh

Box 1. Typical DCC activities

- Operating theatre sessions
- Outpatient activities
- Ward rounds
- Emergency duties
- Administration directly related to patient care
- On call duties
- MDT meetings and preparation for these

Box 2. Typical Supporting Professional Activities (SPA)

Core:
- Continuing professional development
- Job planning
- Mandatory training
- Appraisal and revalidation

Other:
- Teaching & training, undergraduate and postgraduate
- Research
- Management of doctors in training
- Audit
- Contribution to service management & planning
- Clinical governance activities

Supporting information

www.bma.org.uk/advice/employment/contracts/consultant-contracts/ (updated 7 December 2018). There are separate sections for each of the four home nations.

Job planning for your first consultant post. Guidance from the Scottish Consultants Committee, BMA Scotland (2014). (Available by following links in the BMA URL in reference above)

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Ray D, Aitken H. Supporting professional activities and job planning – a survey of consultant anaesthetists working in Scotland. *Anaesthesia News* 2017; **361:** 16-8

Consultant appraisal – a Clinical Director's perspective

All doctors in training are aware of the need to present an annual summary of their work to a panel of clinicians who will, in turn, provide a summative assessment of their performance (Annual Review of Competence Progression; ARCP). Once training is complete and doctors commence solo or independent practice, the need to maintain a portfolio for review is retained although the processes upon which it is then used differ. Whilst the ARCP is structured as a pass or fail exercise, the annual consultant appraisal discussion is facilitated by a single trained appraiser and is a formative exercise and therefore developmental rather than 'pass/fail'. Since 2012, the requirements for the newly 'strengthened' medical appraisal have been dominated by the need for doctors practicing in the UK to revalidate and therefore renew a licence to practice every five years.

Debate about the precise nature of medical appraisal has been heated, with concern expressed in some quarters over the lack of any formal assessment of knowledge, skills and task performance and the absence of independent scrutiny of doctors. Despite this, a revalidation process for UK doctors was developed based largely on the completion of five annual appraisals. With the addition of validated multi-source feedback exercises, a formal link to an organisation and the requirement of a recommendation from a 'Responsible Officer' (who can utilise information from that organisation's clinical governance systems [1]), it was hoped that the public would be satisfied they would be treated by doctors that are demonstrating ongoing professional development.

A 'strengthened' medical appraisal today is a process of 'facilitated self-review' of the complete scope of their work [1], and requires the doctor to show that they continue to meet the principles and values of the GMC's Good Medical Practice (GMP). An annual portfolio of 'supporting information' from six categories (Table 1) is used to demonstrate this with all submissions matched to four GMP domains (Table 2). Medical Royal Colleges have produced guidance frameworks that assist their members in covering the breadth of their practice with their continuing professional development activities such as the RCoA CPD Matrix. It is understood that a broad portfolio is built over years and that each subspecialty interest may therefore not be developed each year.

Table 1. Annual portfolio categories of supporting information

Category	Supporting Information
1	Continuing professional development
2	Quality improvement activity
3	Significant events
4	Feedback from colleagues
5	Feedback from patients
6	Review of complaints and compliments

Table 2. Good Medical Practice (GMP) domains:

Knowledge, skills and performance
Safety and quality
Communication, partnership and teamwork
Maintaining trust

The presentation of supporting information is less important than the way it is interpreted by the appraisee through personal reflection. Through this process, critical appraisal of the activities described (CPD, significant event, feedback exercise, etc.) can be used to consider how it could be used to enhance the quality of patient care they can offer.

Alongside the supporting information and reflection provided, doctors should use the appraisal process to continually improve the quality of the practice they offer through a series of personal objectives within an agreed Professional Development Plan (PDP). The appraiser should ensure these objectives are well defined, achievable and have a timescale for completion. The appraisal meeting is concluded by an important discussion around their career aspirations and anticipated challenges in the year ahead and agreement with a number of declarations regarding the doctor's health and probity. Whilst time consuming in its preparation, medical appraisal should be recognised as a positive experience with the aim to support consultants to develop. The appraisers' role is to facilitate this development and aid the Responsible Officer in ensuring doctors continue to provide the highest quality care for the public once practicing independently as consultants.

Nick Parry
Consultant Anaesthetist
Clinical Director - Theatres, Critical Care, Anaesthetics and Pain
The Dudley Group NHS Foundation Trust

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Top Five Tips!

1. Reflection is crucial – but doesn't have to be on everything! Try to write some reflections at the time of the 'event' – be it CPD, significant event, multisource feedback etc. It is preferable to have high-quality reflection on a limited number of supporting items (including impact on personal practice in the future) than a few hurried words on everything.

2. Consider your prospective Professional Development Plan (PDP) ahead of the appraisal meeting. This will enable the items selected to more accurately reflect your aspirations and ambitions for the future. Chosen items could be CPD courses/qualifications, but could reasonably also include relevant Quality Improvement projects, development of new clinical skills, shadowing of other colleagues, etc. They also do not have to be completed within 12 months as long as progress is monitored.

3. How many of these do I need? There are few set requirements about the number of supporting information items that need to be inputted into the appraisal. You do not need a set number of incidents reported, audits undertaken, and items in your PDP. Much more important is the extent to which you demonstrate engagement with clinical governance systems, quality improvement etc. as well as showing how these activities affect your ongoing personal practice through reflection.

4. Ensure you cover the full extent of your scope of practice in your appraisal. In respect of your supporting information, CPD, reflective writing, PDP etc., you should ensure that each area of your clinical and non-clinical work (and place of work) is represented. Clearly, you cannot undertake CPD to cover all areas of your practice every year, for example, but this should be considered over each 5-year revalidation cycle.

5. Think positively! It is important to have supporting information that reflects positive events in the appraisal. Positive incidents that you are involved with as well as compliments, good multisource feedback, good clinical outcomes etc. should all be included alongside any adverse events or incidents that relate to your practice.

Workforce planning in Ireland – what does the future hold?

In 2016, the National Doctors Training and Planning unit within the Irish Health Service Executive (HSE) developed and published their methodology for medical workforce planning in the Republic of Ireland [1]. The methodology is being used to predict the medical workforce requirements for public and private care over a defined ten year projection period. The approach consists of five phases: set the context, analyse the major drivers of change to the workforce, develop a stakeholder informed set of future workforce scenarios, analyse the future gap between the supply of and demand for staff, and, develop the workforce plan.

Methodology

The National Clinical Programme for Anaesthesia (NCPA) [2] has facilitated the development of a Model of Care for Anaesthesiology to assist planning the future workforce requirements in the disciplines of anaesthesiology, intensive care and pain medicine. This work was strongly supported by the College of Anaesthesiologists of Ireland and the Irish Standing Committee (ISC) of the Association of Anaesthetists.
The draft model of care, published in October 2018, sets the context and outlines a model of care suitable for the next ten years. It considers the standards required for the provision of scheduled and unscheduled 24-hour care, the need for a retrieval service, and the provision of pain medicine services nationally. It recommends engagement in quality improvement, postgraduate training and continual professional development by all anaesthesiologists. All of these are consistent with the national health care strategic plan (Slaintecare) [3].

The Model of Care for Anaesthesiology sets out the requirements to deliver safe, internationally acceptable levels of anaesthesiology care throughout Ireland, irrespective of whether the patient is being cared for in a Model 2, 3 or 4 hospital setting [4]. To provide this care, the anaesthesiology team needs to collaborate with colleagues from other disciplines, who are similarly planning for the future [5].

Evolving role of the anaesthesiologist

In the past decade the role of the anaesthesiologist has evolved from being a theatre-based specialty to one involved in critical care, resuscitation, pain medicine, the provision of anaesthesiology for radiological, cardiac and other procedures outside the theatre environment, transport of the critically ill, and responding to critically ill or deteriorating patients on wards or in the emergency department. This future orientated workforce plan considers the continued evolving role of the anaesthesiologist.

'2 plus 2 model' of anaesthesiology/critical care cover for unscheduled care

A comprehensive anaesthesiology/critical care service requires a team structure that enables the delivery of an elective service and an emergency anaesthesiology/critical care service on a 24 hour basis. The emergency team must be able to provide an immediate and sustained response to more than one emergency. Second emergencies – such as a category-1 Caesarean section or a cardiac arrest in the emergency department, intensive care unit (ICU), or on the wards, as well as the transfer of critically ill patients to other hospitals – can arise while the team is already involved with other operating room cases. In the context of previously published safety recommendations [6-8] the 24 hour provision of a clinically appropriate safe anaesthesiology/critical care service for unscheduled care is a major challenge. To provide such a comprehensive service in Model 3 hospitals, which, along with a critical care and anaesthesiology service may have a co-located obstetric unit with a possible addition of a trauma service, the Model of Care recommends the '2 plus 2 model' of cover (two consultant and two NCHDs) for unscheduled care as the minimum acceptable cover for 24 hour unscheduled care.

In the area of particular subspecialties, such as cardiothoracic, neuro-anaesthesiology, and transplant services, the long-term national goal should be to create larger subspecialty centres, geographically sited according to population need, with clearly defined referral patterns. These centres should be staffed with an adequate number of appropriately trained subspecialty consultant anaesthesiologists, thereby providing a comprehensive 24/7 service.

Additional posts

As a first step, providing the '2 plus 2' cover in hospitals in all maternity units would require an additional 74 consultant posts and 43 NCHD posts. Significant reconfiguration of services involving many of the smaller units would reduce this figure. Consultant posts in the Irish health service must be attractive and well-structured, with reasonable on-call commitments, and provide the incumbents with the opportunity to use their skills/training appropriately. The Model of Care espouses a 1 in 8 on call roster frequency and adequate non-clinical time for administrative, teaching & research activities.

The College of Anaesthesiologists of Ireland will continue to train sufficient numbers of consultants in the various subspecialty areas in order to provide the numbers required to implement the vision of this model of care.

Jeremy Smith
Clinical Lead, National Clinical Programme for Anaesthesia

Martin McCormack
Chief Executive, College of Anaesthesiologists of Ireland

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Aluminium release by coated and uncoated fluid-warming devices

Perl T, Kunze-Szikszay N, Bräuer A, et al.

As clinicians, we tend to take for granted that the drugs and products we use have been thoroughly tested and will not harm our patients if used correctly. Perl and colleagues questioned this dogma and conducted an important study that examined a commonly used fluid warming device. The authors performed a bench study that looked at the concentrations of aluminium in normal saline or balanced fluid solutions which had been warmed with one of two devices: the coated Fluido Compact and the uncoated enFlow device. They found that the coated device performed well in terms of aluminium release, regardless of temperature, duration of use and type of fluid administered. However, on running balanced fluids through the uncoated enFlow device, they found that potentially dangerous concentrations of aluminium were found in the fluid. Concentrations of up to 140 times the FDA suggested limits of safety were found, and high concentrations of aluminium were demonstrated regardless of whether the device was actively warming the balanced fluid or not, the duration of use and the flow rates of fluid administration. The administration of toxic concentrations of aluminium to patients has been linked with several catastrophic neurological conditions, particularly in the developing brain, but also in the older yet susceptible brain, potentially leading to Alzheimer's disease. These findings have been widely reported, have led to widespread recall of the enFlow device and sparked an interesting discussion by Charlesworth and van Zundert (editorial published in the same issue) about how we as clinicians should safely incorporate medical devices in to our daily practice.

Guidelines for day-case surgery 2019. Guidelines from the Association of Anaesthetists and the British Association of Day Surgery

Bailey CR, Ahuja M, Bartholomew K, et al.

These guidelines have never been so important or timely, with the ongoing push for 75% of all surgery to be performed as day-case. Given that most surgery is probably suitable as day-case procedures, clinicians needed these guidelines to help support planning, clinical decision-making and operational development. In particular, protocol-driven, anaesthetist-led clinics, along with the need for local day-case leads are advised. Notably, the use of ASA physical status as a marker of suitability for day-case surgery should no longer be used, but rather the patient's functional status. One of the most important recommendations for clinicians is that regional anaesthesia and spinal anaesthesia should be considered to enable early discharge. The question arises as to whether all clinicians will be able to deliver this standard of care, and how feasible day-case spinal is in all centres. Regardless, it is something to strive towards. These guidelines also provide some invaluable guidance on the types of urgent surgery suitable for day-case as well as the pain categories of different types of surgery. Several processes are amenable to audit in various day surgery processes, and these guidelines provide a simple guide as to what outcomes should be explored for future audit of care. These guidelines will become a staple for anyone involved with any aspect of day-case surgery.

N.B. the articles referred to can be found in either the latest issue of *Anaesthesia* or on Early View (ePub ahead of print)

Kariem El-Boghdadly, Editor *Anaesthesia*

Consultant interviews – a Clinical Director's perspective

Being the Clinical Director (CD) of a department is often perceived as a thankless, poisoned chalice where budgetary constraints prevent the post holder from effecting any real change. At best one manages to walk the tightrope of implementing change pushed forward by management while protecting the service from the worst budgetary decisions.

One of the most powerful legacies of a CD, therefore, can be the new consultants we appoint into the department. A legacy that in most cases will last well beyond the working life of the CD, as most consultants once appointed will stay in their hospital until their retirement. It is an enormous responsibility as the appointment of an individual who does not work well with other team members will have a lasting negative effect on the department. During my nearly seven years as CD of theatres, anaesthesia, intensive care (for three years), pain and pre-assessment, I appointed 34 substantive consultants, and was therefore involved in the appointment process of approximately one-third of the current workforce.

The process of getting consultant posts approved can be long and bureaucratic, but knowing there is a highly qualified candidate interested can help its progress, and I recommend declaring interest in working a particular hospital early. The CD can give an idea of when a consultant post may be advertised and having an idea of potential candidates interested in a position may help the process along. I always found it strange that people would apply for a consultant job without making any contact with the Head of Department to declare their interest or find out the background to the post.

Shortlisting can be a drawn-out process. If there are a lot of applications it may not be possible to shortlist everyone who meets the person specification, so only the top scorers will go through. When filling in the application form make sure you write it clearly and succinctly to ensure the shortlisting person can quickly pick out your 'unique selling points'. I always prefer bullet points to long blocks of text. After being shortlisted it is customary to make contact with most of the panel, but usually not the lay chair or the RCoA representative. Most people bring their nicely bound CV, but I generally prefer seeing a one-page condensed summary with all the information that is relevant to me.

The interview panel can come across as intimidating, but we generally make every effort to put the candidate at ease. If there is a presentation included you will come across as more professional if you are standing up, even if there is a seat available. Make sure you run to time, answer each question to the person who asked it, and keep your answers structured. Avoid talking for more than a couple of minutes for each answer – the interviewer can always ask follow-up questions if you went in a different direction to the one they expected.

If you are unsuccessful don't be afraid to ask for feedback on your interview. It may show you a new angle on your performance and how you come across. Above all, enjoy it – I still remember my consultant interview 12 years ago as if it were yesterday. Be calm, speak at half the speed you think you need to, and look professional.

Helgi Johannsson
Consultant Anaesthetist
Imperial College Healthcare NHS Trust, London

Consultant pre-interview visits – what to talk about?

Data gathered by the Royal College of Anaesthetists indicate that there are, on average, 350 anaesthetic Advisory Appointment Committees (AACs) supported by the College each year. The total number of consultant posts appointed to nationally will be in excess of this as Foundation Trusts are not obliged to seek College representation on their panels. In addition, some AACs cover more than one post. College records indicate that 400-450 anaesthetists enter the Specialist Register each year via training schemes, plus those who achieve 'equivalence' or move to the UK from overseas. Supply and demand are, therefore, quite finely balanced so it is important to put yourself in the best position possible to secure the job of your dreams!

An AAC is a legally constituted interview panel that must include five core members or their representatives: a lay member (usually the Chairman of the Trust or other Non-Executive Director); a College Assessor; the Chief Executive of the Trust; the Medical Director; and, a consultant representative from the Trust, usually from the relevant specialty. AACs for posts with research or teaching responsibilities will also have a university representative.

Shortlisting for the post will be determined by your application and sometimes CV. Once you have been shortlisted, you need to put yourself in the best position possible for the day of interview. You should be notified of the names of the panel members when you are sent details of the interview. You should expect to meet, or at the very least, have a telephone conversation with the Chief Executive, Medical Director and specialty consultant. Make contact with the Chairman or Non-Executive Director but don't be surprised if they decline your offer to visit. The College assessor (there to advise on your training and qualifications) and university representative wouldn't be expected to have an in-depth knowledge of the post, so don't arrange to meet them.

Pre-interview visits do not form part of the appointment process but the panel will still get an impression of you when they meet, so make sure it's a good one. Do your homework about the Trust and the department you want to join - there is nothing worse than a candidate who has not researched the place they want to work in for up to 30 years! Find out if the department has had a recent peer review, ACSA visit or if the Trust has had a CQC inspection recently. Get hold of the reports and skim read them for salient points. Go onto the Trust website and read any recent Trust Board papers. You can often pick up topics to discuss with the Chief Executive or Medical Director from those. The Board papers also will give an indication of the Trust's financial position, operational performance and quality measures.

Pick up clues

Use the pre-interview visit to pick up clues for your interview. When you meet, ask the Chief Executive about the wider Trust strategy and how they see the Department of Anaesthesia helping with that. Ask about their priorities for the organisation and challenges they face. Speak to the Medical Director about clinical matters - quality and safety performance and involvement of the consultant body in quality improvement. The specialty consultant (often the Clinical Director or Lead) is the person to talk to about the job itself. Find out what you need to know about rotas and the proposed job plan. Does it meet your needs and is there anything in particular that they need from the new appointee that you can talk about at interview? Finally, when visiting the Trust, don't waste the opportunity to call into the department and see if there are any staff available you can talk to, either prospective consultant colleagues or trainees, to help give an insight into the culture of the department.

Julian Berlet
Consultant Anaesthetist
Divisional Medical Director
Worcestershire Acute Hospitals NHS Trust

Consultant interviews – a new consultant's perspective

Once you approach the end of training the daunting prospect of the consultant interview is upon you. Hopefully you will have an idea of where you want to work – choosing a department that offers you not only the clinical and non-clinical opportunities that you want, but also one with colleagues that you would like to spend the next potentially 30 years of your life working alongside. After you have painstakingly filled out the job application (and this always takes longer than you think) and have been shortlisted, the fun really begins. Just remember that you need to prepare for it like anything else, with lots of practice, which for me involved a lot of background reading, an interview course and a lot of grilling from friends and colleagues!

It's not just the interview itself that you need to prepare for, part of the preparation also involves meeting people, preparing your CV and making sure you are ready to look the part. There is always the challenge of who to meet prior to the interview. Department Leads, the College Tutor, if you are applying for a subspecialty role (paediatrics, neuro, pain, or a combined ICM job, for example) then their leads too. Don't forget theatre managers and hospital management; ask for advice from colleagues as everywhere is different. These meetings can vary from someone telling you all about their vision for the department or hospital (with very little space for you to talk), through to you being grilled as though this was your interview, so be prepared for any eventuality. Do I give people a copy of my CV? You will never make everyone happy with your CV, some will want a full CV, some a précis on two pages, a hard copy or an emailed PDF. The most important thing is that you are comfortable with what you are giving them, after all it represents you.

Finally, the interview. This may or may not involve a presentation. If it does, have several formats of your slides available just in case there is an IT failure on the day, ask to see the room in advance so you know the equipment and layout. The interview panel may appear like a firing squad – the panel sitting around a very large table and all looking directly at you! The panel will be diverse – from the College representative to a lay chair, several members of the anaesthetic department and maybe an academic or manager. Be confident – smile!

Remember it's not the same as a viva, there is not necessarily a right or wrong answer to many of the questions, it should be a conversation between you and the panel members, so be yourself. We often find it really difficult to talk about ourselves – this is not the time to be shy, you need to be able to sell yourself and all your accomplishments. The one thing you can be guaranteed to be asked about is yourself!

After my own interview someone said to me that appointing a substantive consultant, seeing that culmination of many years of hard work, for it to come down to that one last hurdle, and to then tell that candidate they are successful – well there is nothing quite like it.

Stephanie Cattlin
Consultant in Intensive Care Medicine
Imperial College Healthcare NHS Trust

ST7 year and beyond...

I am sitting here writing this on the last ever shift that I am going to complete as an anaesthetic registrar on what, tonight, has been a rare moment to sit down. Whilst this has been a longer than average time coming (extension to complete my Primary, babies and working 'less than full time') I am not sure that I was fully prepared for my ST7 year and how stressful a time it would be. In several aspects it feels as if the training wheels are being shaken loose but I am not sure if I am fully ready to go without them yet.

I have been in the privileged position of having seen many of my fellow core trainee colleagues successfully completing their ST7 year and gaining consultant posts. However, nothing had prepared me for how intense I would find it being on call with my consultant colleagues who I knew would be interviewing me at the end of the week. Working at a hospital during ST7 where you are interested in securing a job seems like a good idea, and often is; however, this does come with the added stress of feeling like you are in a constant job interview. Some people thrive on this, whilst others might find the pressure too much, and it is certainly something to think about when planning your hospital rotations. Having job adverts come out within days of one another, and interview dates all within one week, pose their own dilemmas when deciding what to apply for and then, if successfully short-listed, which interviews to attend. My advice here would be to only apply for jobs if, at that time, you are seriously considering it as an option, and only accept an interview for those you would be willing to accept the job.

Enhance your chances

Not all ST7 trainees decide to go straight into a consultant post, and that is fine. I have successfully secured a post-CCT paediatric fellowship and am currently embracing the upcoming sub-speciality training. If choosing to pursue a fellowship, my advice would be to make sure that it is the correct addition to your training, and that it is going to enhance your chances of securing your desired consultant post. Others may choose to enter their six months grace period either through choice (to further augment their existing training) or because they have not yet secured a consultant post. A further option would be to resign at the end of your training (providing you are on track to complete your anaesthetic training) and do ad-hoc locum shifts. Whatever your decision, it needs to be the correct one for you.

To make the most of your ST7 year it is essential you keep on top of the requirements. Most trainees will be completing their advanced training year during this time and ensuring that this is completed with the required work-place based assessments is essential. The additional advanced domains need to be completed and it is certainly a psychological advantage to go into your final ARCP with all, or nearly all, of the pre-requisites done. Make sure you are aware of what is required in your Deanery as the exact requirements may differ. Did you know that in order to get your CCT you need to have paper and electronic copies of all ARCP outcomes from your training? If training has taken longer than the standard seven years then this can amount to a substantial number of ARCP forms. Even for someone who is as meticulous as I am with keeping paperwork, I needed help to ensure all the years were covered. Your Deanery should be able to provide you with copies of any that you are missing.

To survive your ST7 year and complete your anaesthetic training by gaining your CCT requires a good support network and help from those who understand the additional requirements, stressors and emotions of the year that completes your training. Do not be afraid to talk to those around you, both professionally and personally. You may be amazed how supportive people can be. Most of all try and enjoy part, if not all, of your ST7 year; this is the end of your education to date and then you will start a new chapter.

Katy Miller
Post-CCT Fellow Paediatric Anaesthesia
Elected member Trainee Committee & Trainee Network Lead Officer

How to write a local guideline

Guidelines are 'systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances' [1]. The purpose of a local guideline is to help healthcare professionals with regard to the specific patients, services and infrastructure present in a department, hospital or trust. Writing a guideline can be an opportunity to review your current situation, define best practice and help the whole team deliver high quality care.

What is the problem?
Clearly identify a clinical problem of relevance to your patients. It may be an area of clinical practice with significant variation that would benefit from standardisation, an area of developing practice with limited local knowledge or experience, or the adaptation of existing national guidance to fit your specific service provision. You should carefully consider the scope of your guideline:

- Which patients / procedures / clinical situations are included?
- Are there circumstances when the guideline should not be used?
- Avoid making your guideline too broad (when it might become cumbersome to use) or too narrow (thereby forcing people to look at several guidelines when one would suffice).

Who is going to use your guideline?
Identify your target audience and make it as relevant as possible to this group. Obtain input from other stakeholders (e.g. from different clinical areas or departments) that may be affected by it or who are required for implementation. Collaborating with other users when developing a guideline will avoid unforeseen problems, provide opportunity for sense-checking and give collaborators a sense of ownership – invaluable when the time comes for dissemination and implementation.

How does this guideline help?
Your guideline must assist its intended users in addressing the problem(s) identified. Its design should match the clinical situation in which it will be used. Guidelines for emergency use should be pared down to easily readable essential information [2]. Those concerning less urgent situations will benefit from more detail to explain the reasoning behind recommendations [3]. Consider what information you and other users will find helpful.

Guidelines should be written so that recommended actions can easily be followed by all users. This requires clear, concise and straightforward language supplying an appropriate level of content and detail. Try to avoid acronyms, abbreviations and jargon; if you must use them, define what they mean. Avoid ambiguity; readers should not have any questions that are unanswered by the guideline. Reference existing guidelines and policy, and avoid overlap or contradiction. Your institution may have a guideline on how to write guidelines, which is sure to help.

Implementation
Consider whether you need to trial any aspects of the guideline before general use; feedback from users can significantly improve your design. Present and publish in a manner that is easily accessible and can be readily updated. Include appropriate search terms so it can be found when needed. Your guideline may need to be approved by your institution's guidelines committee before it can be used in practice. Ensure that everyone who might use the guideline is aware of it; present it at as many meetings to as many groups that might need to know.

What patient, staff and organisational benefits do you hope to achieve by implementing your guideline? Decide which process and outcome metrics can be (easily) measured to assess its impact, and how frequently these should be evaluated. There may be departments within your organisation able to help with the data collection and analysis. Consider how soon the guideline needs updating and identify someone responsible for doing so.

Sam Marcangelo
Trust Grade Anaesthetist

Ben Goodman
Consultant Anaesthetist

The Newcastle upon Tyne Hospitals NHS Foundation Trust

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Anaesthesia News is seeking to appoint a new Managing Editor

About the role

This role offers excellent opportunities for a practicing or recently retired anaesthetist to develop this successful monthly publication for the Association's members. It is a hands-on role, working with and supported by an editorial committee and by experienced in-house editorial and design staff to ensure the publication furthers the goals of informing, engaging and educating Association members.

An average of approximately 20-30 hours per month may be required, which can be worked flexibly to fit the editorial schedule and the editor's job plan. Most work is carried out online, enabling the editor to manage tasks from his or her own location, either at home or place of work.

The Association has recently re-branded and is implementing a digital communications strategy, launching a new website in 2019 and ongoing digitalisation of our publications. This is an exciting time for the new Managing Editor to take forward the publication.

Help shape the future of the Association's member magazine

Recruitment timeline and process

For an informal discussion about this role please contact the interim Managing Editor, Dr Mike Nathanson or the Executive Director, Karin Pappenheim, on either **secretariat@aagbi.org** or **0207 631 8807**. A full role description is available.

How to apply

Candidates are asked to submit electronically: a CV; a letter of application (maximum 400 words) describing the reasons for applying for this role and their skills/experience offered in relation to the person specification; and, a personal statement (maximum 600 words) setting out the applicant's vision for the future development of *Anaesthesia News* as a print and digital publication.

Association of Anaesthetists

Closing date for applications
Applications should be sent by **5pm on Friday 19 July 2019** to **secretariat@aagbi.org**

Selection process
Candidates will be invited to attend an interview with Officers of the Association at our offices in London on **Friday 9 August 2019**.

Your letters

Send your letters to:The Editor, *Anaesthesia News* at anaenews.editor@aagbi.org
Please see instructions for authors on the Association's website

Dear Editor

Spirometry sensor mal-position


Figure 1


Figure 2

In the middle of an anaesthetic we noticed the green adult spirometry sensor (Intersurgical Ltd, Wokingham, UK) for GE anaesthetic machines sat at an angle and was not flush (Figure 1). There was no leak and spirometry measurements were correct. It could not be pressed flush because the internal tube of the 'double' male connector had become deformed on one side during assembly (Figure 2). The equipment had been used for two days before without incident and was changed for a new system. An immediate inspection of our 40 anaesthetic machines revealed three more 'not-flush', poorly assembled spirometry sensors. When asked, three colleagues had experienced a spirometry disconnect. Not attaching this piece securely risks the spirometry connector falling off with the potential for delay in re-attachment in either prone or drape-hidden, shared-airway patients. We have reported the incident to the MHRA and the manufacturers.

Christopher C Jackson
Trainee Anaesthetic Practitioner

William FS Sellers
Locum Anaesthetist

University Hospital Coventry and Warwickshire

Reply

Thank you for the opportunity of responding to the report submitted by Dr Sellers. We have duly investigated this incident and confirmed that the returned products were within the expected specification and no manufacturing fault was identified; however, it is important that the spirometry sensor connector is aligned correctly when attached to the sensor in order to avoid the possibility of deformation as highlighted. We therefore plan to conduct further usability studies to assess if any update to the instructions for use are required. This report further reinforces the importance of pre-use checks of all components and connections within the anaesthetic breathing system prior to use.

Sean Duggan
Anaesthesia & Filtration Group Product Manager
Intersurgical Ltd

Dear Editor

I read with interest the remarkable achievement of the anaesthetic department of North Bristol NHS Trust in acquiring two sleep pods to improve the rest facilities available for their trainees (Anaesthesia News, March 2019). Despite their best efforts and creative solutions, it is unfortunate that they have become undone by motion-activated office lights. I would like to reassure them that this problem is not unique to them and it is something which has plagued trainees across the country for a number of years. They will find in their ongoing discussions with the Estates Department that the cost of changing to an old-fashioned switch-operated light system will come at a greater cost than their sleep pods, so I offer them a tried and tested alternative. After years of experimenting we have found the best solution to this problem is covering the motion sensor with a circular ECG electrode. It is cheap, easy to site and remove, requires no tape, and causes no damage to the sensor or ceiling. I hope this provides the final solution in your quest for rest.

Mohammed Akuji
ST7 Anaesthetist
East Lancashire Hospitals NHS Trust

Editors' note: the Association can't recommend this action, as it is interfering with a fitting in the building, but we thank Dr Akuji for bringing his solution to our attention.

Dear Editor

Heal Thyself - documentary

I'm an anaesthetist and filmmaker. The wellbeing of doctors has never been more topical and this year I'm making a documentary film about mental health and suicide in the profession. In order to make this film I need to hear from my colleagues across the profession, anaesthetists and others. We've all experienced the highs of lows of being a doctor, the sleep deprivation, fielding complaints and bad patient outcomes. Some have experienced more serious mental health problems affecting work and home life, and others touched by the suicide of colleagues. Whatever your experience, please get in touch for a chat. We can do things confidentially if you prefer. Your contribution could be so valuable.

Thom Petty
www.lostnortherner.com
Email: info@lostnortherner.com

Editors' note: Dr Petty's project aligns with the Association's wellbeing aims but is independent of the Association. We have considered the possible implications of colleagues speaking about their personal experiences and believe Dr Petty has appropriate processes and safeguards in place.

Particles

Chu DK, Kim LH-Y, Young PJ, et al

Mortality and morbidity in acutely ill adults treated with liberal versus conservative oxygen therapy (IOTA): a systematic review and meta-analysis.

Lancet 2018; **391:** 1693-1705

Introduction

In the UK supplementary oxygen is administered to 34% of patients in ambulances, 25% of patients in emergency rooms [1] and 15% of patients admitted to hospital [2]. Although adequate oxygen delivery is required to treat hypoxaemia, there is increasing concern about the potential deleterious effects of excessive oxygen supplementation [2, 3]. Current guidelines on the use of supplementary oxygen in acutely ill adults are contradictory and inconsistent. The primary objective of this study was to systematically review randomised controlled trials investigating the efficacy and safety of liberal versus conservative oxygen therapy in acutely ill adults.

Methods

The Improving Oxygen Therapy in Acute-illness (IOTA) systematic review and meta-analysis pooled the results of 25 RCTs comparing liberal and conservative oxygenation strategies in acutely ill adults (≥ 18 years). The liberal arm was defined as the higher oxygen target, measured by any one of the following: FiO_2, PaO_2, SaO_2 or SpO_2 and the lower oxygen target (including room air) was defined as the conservative arm. Studies were excluded if patients were < 18 yr old, pregnant, limited to patients with chronic respiratory diseases, psychiatric disease, patients on extracorporeal life support, and patients treated with hyperbaric oxygen therapy or undergoing elective surgery. The main outcomes were mortality (in-hospital, at 30 days and, at the longest follow-up) and morbidity (disability at longest follow-up, risk of hospital-acquired pneumonia, any hospital-acquired infection and, length of hospital stay) assessed by random-effects meta-analyses.

Results

The trials included over 16 000 patients with critical illness, trauma, sepsis, stroke, myocardial infarction, cardiac arrest and patients who had emergency surgery. Compared with a conservative strategy, a liberal oxygen strategy (median baseline SpO2 96% across trials [range 94 – 99%]) was associated with increased mortality in-hospital (RR 1.21; 95% CI: 1.0-1.43, p = 0.02), at 30 days (RR 1.14; 95% CI: 1.01-1.29, p = 0.03) and at longest follow-up (median 3 months) (RR 1.10; 95% CI: 1.00-1.20, p = 0.04). Morbidity was similar across the two groups. Findings were robust to trial sequential, subgroup and sensitivity analyses.

Discussion

In acutely ill patients, liberal oxygen therapy increases mortality without improving other outcomes. The authors conclude that supplementary oxygen to achieve SpO2 above 94 – 96% might be unfavourable.

Conclusion

This is a comprehensive and up-to-date systematic review and meta-analysis which is consistent with previous studies - an association between liberal oxygen therapy and increased mortality in acutely ill adult patients. Although the review was limited in terms of variability in the intervention, this allowed identification of a dose-response relationship whereby increasing liberal oxygen therapy was associated with increasing mortality risk. However, the precise mechanisms of harm of hyperoxia were not identified so future research is required to more accurately determine specific oxygenation targets that maximise benefits whilst minimising harms.

Seliat Sanusi
Perioperative Medicine Fellow, UCLH

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