SEPTEMBER 2019

Bulletin

The magazine for members of the Royal College of Anaesthetists

Centre for Perioperative Care

A collaboration of specialties to advance patient care

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RCoA Royal College of Anaesthetists

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RCoA Events

Further information about all of our events can be found on our website.

www.rcoa.ac.uk/events
events@rcoa.ac.uk
@RCoANews

SEPTEMBER

New to the NHS
16 September 2019
General Medical Council, Manchester

Introduction to Leadership and Management: The Essentials
23–24 September 2019
Bristol

Advanced Airway Workshop
24 September 2019
RCoA, London

Updates in Anaesthesia, Critical Care and Pain Management
24–26 September 2019
RCoA, London

WICM 2019 Meeting: Striking a Balance
27 September 2019
RCoA, London

Developing World Anaesthesia
30 September 2019
RCoA, London

OCTOBER

Anaesthetists as Educators: An Introduction
1 October 2019
RCoA, London

Return to Training Network Meeting
2 October 2019
RCoA, London

Anaesthetists as Educators: Simulation Unplugged
2 October 2019
RCoA, London

Leadership and Management: Leading and Managing Change
7 October 2019
RCoA, London

Ultrasound Workshop
8 October 2019
RCoA, London

A Career in Anaesthesia: Foundation Year Doctors
9 October 2019
RCoA, London

CPD Study Day
17–18 October 2019
Crowne Plaza, Newcastle

Less Than Full Time Matters 2019
17 October 2019
Association of Anaesthetists, London

GASagain (Giving Anaesthesia Safely Again)
18 October 2019
RCoA, London
FULLY BOOKED

UK Training in Emergency Airway Management (TEAM)
28–29 October 2019
RCoA, London

WINTER SYMPOSIUM 2019

Patient safety, health and wellbeing

10–11 December 2019
RCoA, London

The 2019 Winter Symposium will feature a varied programme combining lectures and short updates.

www.rcoa.ac.uk/winter-symposium-2019

Discounts available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

NOVEMBER

Updates in Anaesthesia, Critical Care and Pain Management
4–6 November 2019
The Studio, Birmingham

UK Training in Emergency Airway Management (TEAM)
7–8 November 2019
Royal Infirmary of Edinburgh

RCEM/RCoA Major Trauma Study Day
13 November 2019
etc venues Prospero House

Anaesthetists as Educators: Teaching and Training in the Workplace
14–15 November 2019
RCoA, London
FULLY BOOKED

Clinical Directors Meeting
18 November 2019
RCoA,London

Leadership and Management: Working well in Teams and Making an Impact
20 November 2019
RCoA, London

Anaesthetists as Educators: Anaesthetists' Non-Technical Skills (ANTS)
22 November 2019
RCoA, London

FPM LPMES Day 2019
28 November 2019
RCoA, London

FPM 12th Annual Meeting
29 November 2019
RCoA, London

A CAREER IN ANAESTHESIA

9 October 2019
RCoA, London

www.rcoa.ac.uk/career-anaesthesia-2019

DECEMBER

Anaesthesia Research 2019
2–3 December 2019
The Principle Hotel, York

Winter Symposium
10–11 December 2019
RCoA, London

JANUARY 2020

Tracheostomy Masterclass
10 January 2020
RCoA, London

Primary FRCA Revision Course
14–17 January 2020
RCoA, London

GASagain (Giving Anaesthesia Safely Again)
15 January 2020
Bradford Royal Infirmary

Final FRCA Revision Course
20–24 January 2020
RCoA, London

FEBRUARY

Patient Safety in Perioperative Practice
13 February 2020
RCoA, London

Updates in Anaesthesia, Critical Care and Pain Management
25–27 February 2020
RCoA, London

MARCH

Ethics and Law
11 March 2020
RCoA, London

Ultrasound Workshop
13 March 2020
RCoA, London

Leadership and Management: Personal Effectiveness
19 March 2020
RCoA, London

MARCH

Cardiac Symposium
23–24 April 2020
RCoA, London

MAY

Anaesthesia 2020
18–20 May 2020
Old Trafford, Manchester

Discounts available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

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A simple tear open pack costing just 30p each can be placed in every anaesthetic room

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From the editor

Dr David Bogod

Welcome to the September *Bulletin*.

Much of this month's edition is given over to the evolution of the Centre for Perioperative Care, hereinafter known as CPOC. This has been a project which has moved smoothly through from conception to completion, with much hard work being done on-stage by Council members and even harder work behind the scenes by College staff. My friend and colleague, Dave Selwyn, has been appointed as CPOC's inaugural director, and within these pages he describes the task that he and his board face as this collaborative programme gets underway. CPOC could have a major impact on patient safety and the quality of the patient experience, and is a great example of proper multidisciplinary care involving a host of different specialties, including surgery, nursing, physiotherapy and, of course, patients themselves. In years to come, we may well look back at this as the moment that anaesthesia came out of its slightly nerdy and self-regarding shell and explained to the medical world what we do, how we do it, and how important it is.

Elsewhere, we feature an article by Drs Bhandari and Menon, looking at the rather tortuous process which has led to the licensing of cannabinoids in the UK for treatment of specific conditions, and why this does not seem to have produced the flood of prescribing that might reasonably have been expected. As anaesthetists, we are likely to encounter cannabis and its derivatives in two particular areas – chronic pain, and the interaction of these substances with our anaesthetic drugs. The authors draw some caution, quite rightly, from the current opioid dependency crisis affecting many countries, warning us that, once again, there is a risk of a drug embraced as a public benefit leading to unintended consequences.

Those readers with a bit of extra time on their hands, wanting to travel the UK and meet interesting people, should read the interview with Sian Jagger, the College's Joint Lead Assessor for Advisory Appointment Committees. More AAC assessors are needed to cover the burgeoning number of consultant posts, and this is a great, and relatively painless way, to get involved in the work of your College. The only slight fly in the ointment, as I recall, is trying to find a parking space when you turn up mid-morning in most UK trusts, but you quickly learn to make friends in the Human Resources department with whoever has access to the reserved slots.

Finally, those of a nervous disposition or who have recently eaten may want to avoid Peter Featherstone's 'As We Were...' article, which features one Henry Robert Silvester. Dr Featherstone highlights Silvester's ingenious 1883 experiment with an inflated dog as a buoyancy aid for the rescue of shipwreck victims, this unlikely device being created with the simple use of (a) one compliant dog, (b) a small sharp knife to effect a subcutaneous puncture and (c) a straw or blowpipe to produce surgical emphysema. Wisely realising that a dog may not always be easy to get hold of in such a situation, Silvester went on to demonstrate that he could turn himself into a human lifeboat by the same method.

The Editor-in-Chief is happy to offer a bottle of finest burgundy to any reader prepared to try this one out and produce photographic evidence to confirm buoyancy.

The President's View

The vital role of anaesthesia in improving the health of individuals and populations

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Professor Ravi Mahajan
President

The global focus on disease prevention over two decades has led to important reductions in death and disability. However, these gains have not been mirrored by global improvements to health systems, service integration, or hospital-based care. In fact, globally, more people die annually within 30 days of surgery than from HIV, tuberculosis, and malaria combined (bit.ly/2KWEjAT).

Around 10 million patients undergo surgery annually in the UK, and for most of them it is a success in terms of the procedure itself and the care before and afterwards. But while a patient receiving surgery in the UK will have a much higher chance of survival and positive postoperative outcomes, the UK's population is changing and so therefore must our services. There are 250,000 patients at higher risk from surgery, and this number is set to rise.

The long-term sustainability of the NHS requires a shift from treatment of ill health to prevention. Yet in recent years the NHS has moved away from pathway development for services built around prevention and focused its efforts on immediate, acute demand. But there is a change in the wind.

In this President's View, I will show that while direct healthcare provision accounts for a relatively small proportion of what makes us healthy, the NHS, and surgical and anaesthesia care, have a vital role to play in improving the health of individuals and populations. And never have the opportunities to place prevention at the core of service design and delivery been better, with the introduction of 'A Healthier Wales', NHS England's Long Term Plan, 'Quality 2020' in Northern Ireland', and the launch next year of Public Health Scotland.

The national picture

Recent UK-wide polling of senior NHS leaders (including those within anaesthesia, intensive care, surgery and general practice) has sought to examine how NHS organisations are responding to the prevention agenda. More than half of those surveyed consider prevention a core or large part of their work, and there is growing consensus that the NHS should prioritise a systems approach to prevention, embedding it into routine practice and clinical and/or patient pathways (bit.ly/2XqTGIl).

The NHS Long Term Plan for England has based its model of care on population health management – gathering data and insights about population health across care and service settings, identifying the healthcare needs of communities, and adapting services. Data analytics and digital technologies offer the tools to make this a reality, helping to identify risks, stratify patient populations and design personalised treatment. This can improve the health and wellbeing of populations and the experience of care, and reduce the costs of care.

The Plan also lays out a renewed NHS prevention programme focused on maximising the role of the NHS in tackling the key risk factors identified by the *Global Burden of Disease Study* – smoking, poor diet, high blood

pressure, obesity, alcohol and drug use, and lack of exercise (bit.ly/2OcMqr0). In England, local NHS organisations will increasingly focus on population health and partnerships with local authority funded services through new integrated care systems.

A population health model will be important in supporting the development of new integrated care systems which, as the Long Term Plan outlines, offer 'a pragmatic, practical way of delivering the 'triple integration' of primary and specialist care, physical and mental health services, and health and social care' (bit.ly/2RnWmAi). It is encouraging to see the alignment of this system-level approach to prevention and population health with the views of NHS leaders.

And, there is much to learn from colleagues across the devolved nations. In Wales, prevention is at the heart of collaboration between the NHS and local government to deliver seamless services for patients, in Scotland more than half of the NHS and adult social care budget is delegated to an integration joint board for each area (apart from Highland), and across Northern Ireland 17 integrated care partnerships are playing a key role in service transformation.

> While direct healthcare provision accounts for a relatively small proportion of what makes us healthy, the NHS has a vital role to play.

The role of anaesthesia in population health

Developing multidisciplinary care and a shared culture will be essential. Clinical and care teams can work together to design patient-centred services. As clinicians, if we are truly to support the NHS to become a wellness, not an illness, service, we all have a role to play in addressing acute and chronic conditions and looking beyond the treatment of patients with recognised problems.

Perioperative care is the integrated multidisciplinary care of patients from the moment surgery is contemplated through to full recovery. Good perioperative care should improve patient experience of care, including quality of and satisfaction with care. It should also improve the health of populations, including return to home/work and better quality of life, and reduce the per capita cost of healthcare through improving value.

Perioperative care is prevention in action. It offers a common thread from national to system/organisational level prevention strategies. It can support NHS organisations by offering a clear role or remit when it comes to prevention that can measure progress. We now have a chance to embed a perioperative care and a population health approach into clinical and patient pathways. We have a chance to think about the current surgical pathway, and how we might review and redesign it to better support our patients in being prepared for surgery, and to think about how and by whom the decision is made that they are optimised for surgery.

> We now have a chance to embed a perioperative care and a population health approach into clinical and patient pathways

We can build on existing tools, and develop new ones for coding and measurement to enable tracking of essential perioperative and preventative activity, supporting our staff who are directly involved in measuring the full impact or effectiveness of their work. And we can communicate that impact to others across their organisations to further encourage or improve delivery. As the survey of NHS leaders has highlighted, this matters because when staff are not directly involved in prevention activity they are more likely to consider prevention interventions to be ineffective or to be unaware of their impact.

Enter the Centre for Perioperative Care

The Centre for Perioperative Care (CPOC), launched in May 2019, is a new cross-organisational, multidisciplinary initiative led by the Royal College of Anaesthetists to facilitate cross-organisational working on perioperative care for the benefit of patients (bit.ly/2X6tAtf).

CPOC will work closely with key stakeholders such as the Royal College of Physicians, the Royal College of Surgeons, the Royal College of Nursing, the Royal College of General Practitioners, the Association of Anaesthetists and other partners to coordinate perioperative care initiatives across the health and social care landscape. CPOC will also work with other partners such as NHS England and the devolved nations' health initiatives such as Realistic Medicine in Scotland and Prudent Healthcare in Wales.

CPOC will support professionals and influence policy, and it will support technology and digital advancements and research and innovation. It will work to inspire professionals and hospitals to better prepare patients for their surgery, increase coordination between specialties and provide cohesive aftercare programmes to enhance recovery and improve quality of life following surgery.

CPOC will aim to combine the best-practice examples already being delivered in hospitals across the UK into shared solutions to improve patients' lives as well as taking the pressure off an already severely pressurised health system. Some of those best-practice examples are highlighted in the RCoA's report, *'A teachable moment: delivering perioperative medicine in integrated care systems'* (bit.ly/2RWIllt).

Anaesthesia-led perioperative care and a population health management approach, offer a route forward that puts patients at the heart of service design and delivery both nationally and internationally. Working collaboratively, we have an opportunity to improve the lives of patients and populations, across the life-course, for generations to come.

You can read more about the aims of CPOC, its scope and multidisciplinary ethos on page 29.

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Bulletin

of the Royal College of Anaesthetists

Churchill House, 35 Red Lion Square, London WC1R 4SG
020 7092 1500
www.rcoa.ac.uk/bulletin | bulletin@rcoa.ac.uk
@RCoANews
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Articles for submission, together with any declaration of interest, should be sent to the Editor via email to bulletin@rcoa.ac.uk

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

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NEWS IN BRIEF

News and information from around the College

RCoA and Macmillan Cancer launch prehabilitation guidance

The College, Macmillan Cancer Support, and the National Institute for Health Research (NIHR) Cancer and Nutrition Collaboration have launched a report calling for changes to the delivery of cancer care across the UK, with a greater focus on prehabilitation including nutrition, physical activity and psychological support.

Seventy per cent of the 1.8 million people in the UK living with cancer are also living with one or more other long-term health conditions. The guidance report, *Prehabilitation for people with cancer*, promotes evidence that when services are redesigned so that prehabilitation is integrated into the cancer pathway:

- patients feel empowered and quality of life is improved
- physical and psychological resilience to cancer treatments is maximised
- long-term health is improved.

Teams from Macmillan Cancer Support, the College and NIHR have worked together to develop these principles and guidance together with an action plan. This sets out how NHS organisations across the UK can replicate some of the pioneering work already taking place at a limited number of trusts – all of which have demonstrated how prehabilitation has improved outcomes and reduced the risk of disease progression.

The document aims to provide guidance to people living with cancer, care providers, commissioners and policy makers. Read the full report at: bit.ly/RCoAMacmillan

Book now for Anaesthesia Research 2019

The College is pleased to announce the launch of Anaesthesia Research 2019, a new two-day event, which will take place at The Principal Hotel in York on 2–3 December 2019.

Led by the National Institute of Academic Anaesthesia (NIAA), the event will incorporate the Anaesthetic Research Society and BJA Research Forum, and all NIAA-affiliated activities including the UK Perioperative Medicine Clinical Trials Network (POMCTN), the Health Services Research Centre (HSRC), and experimental/discovery medicine.

The single day rate is £87.50 or £175 for both days of the meeting. There is a reduced rate of 25 per cent for anaesthetists in training and allied health professionals (£130 across the two days) and a 50 per cent discount (£90 across the two days) for quality audit and research coordinators.

This event promises top speakers and dedicated work streams to provide you with maximum value, for more information and to book your place, go to: bit.ly/RCoAResearch2019

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Centre for Perioperative Care

Dr David Selwyn appointed as Director of the Centre for Perioperative Care

The College is delighted to announce the appointment of Dr David Selwyn as the inaugural Director of the Centre for Perioperative Care (CPOC).

The CPOC is a cross-specialty centre dedicated to the promotion, advancement and development of perioperative care. CPOC will facilitate cross-organisational working on perioperative care for patient benefit, in partnership with patients and the public, other professional stakeholders including Medical Royal Colleges, NHS England and the equivalent bodies responsible for healthcare in the other UK devolved nations.

David brings a wealth of expertise to his new role as a highly experienced consultant in Adult Critical Care Medicine and Anaesthesia and Deputy Medical Director at Nottingham University Hospitals NHS Trust. As Director of CPOC, David will take the lead on facilitating and encouraging cross-organisational and new ways of working to help shape the development of perioperative medicine (www.rcoa.ac.uk/cpoc). You can read more about the aims of CPOC, its scope and multidisciplinary ethos on page 29.

Applying to be an FRCA examiner

The examiner recruitment round is now open until Monday 21 October 2019, recruiting examiners for the academic year 2020–2021. Applicants are recruited to the Primary and Final examiner boards.

The application form and a full list of essential criteria, which must be met on application, are available on the College website at: bit.ly/RCoAExaminer

The FRCA exams in brief

The Primary FRCA OSCE/SOE took place week commencing 14 May 2019. 409 candidates sat the exam with an overall pass rate of 54.3 per cent which is in the normal range.

The Final FRCA SOE took place from 17–21 June 2019. 413 candidates attended the exam achieving a pass rate of 67.3 per cent overall, which is in the normal range.

From September 2019 Constructed Response questions (CRQs) will replace Short Answer Questions (SAQs). The September paper will consist of 6 x SAQ and 6 x CRQ. With effect from March 2020, the paper will consist of 12 x CRQs. Example CRQs can be found on the Final Written page of the College website at: bit.ly/ExampleCRQs

NEWS IN BRIEF

News and information from around the College

Fitter Better Sooner resources nominated for BMA Patient Information Award

The *Fitter Better Sooner* patient information toolkit on preparing for surgery, has been highly commended for the 2019 BMA Patient Information Awards.

Endorsed by the Royal College of General Practitioners and the Royal College of Surgeons, the *Fitter Better Sooner* resources were developed to advise patients on how to prepare for going into hospital and encouraging them to improve their health before surgery. The toolkit consists of one main leaflet, six specific leaflets on some of the most common surgical procedures and an animation designed to be shown in clinic and surgery waiting areas.

The BMA Patient Information Awards were established in 1997 to encourage excellence in the production and dissemination of accessible, well-designed and clinically balanced patient information.

The awards aim to reinforce the BMA's commitment to support good educational practice and acknowledge new approaches and technologies intended for the public audience.

Up to five resources have been shortlisted for each award and the winners will be announced at a ceremony and reception on the afternoon of Tuesday 10 September 2019 at BMA House.

You can view the toolkit at: bit.ly/RCoAPI-FBS

WINTER SYMPOSIUM

10–11 December 2019

The theme of the 2019 Winter Symposium is patient safety, health and wellbeing. In an increasingly pressurised NHS, how can anaesthetists take care of their own health as well as the safety of their patients? The Symposium will be a lively mixture of updates, debates and panel discussions. Hot topics will include the new junior doctors' contract. Experts will bring you up to speed with changes in anaesthetic practice and explore what the next five years may bring.

Enjoy the opportunity to ask questions, participate in discussions and network with your peers.

The Symposium was fully booked last year so book early to avoid disappointment (bit.ly/RCoAWinter19).

2019 SALG Patient Safety Conference

SAFE ANAESTHESIA LIAISON GROUP

The annual SALG Patient Safety Conference will be held on the 31 October this year at the College. As in previous years, we are running an abstract competition for anaesthetists in training to submit their projects for consideration. Further information about the conference and the competition can be found at: bit.ly/2xNZvQN

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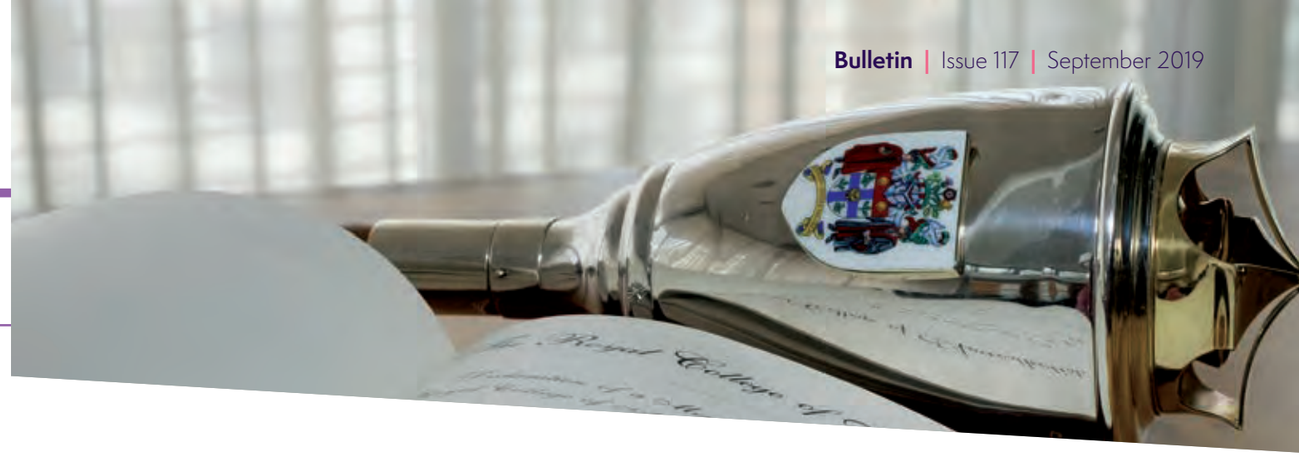

ELECTION TO COUNCIL

Nominations open: election to RCoA Council

Nominations for election to the Council of the Royal College of Anaesthetists are now open. Council comprises 24 seats, made up of:

- 20 consultant seats
- 2 SAS doctor seats and
- 2 trainee seats.

The vacancies and timetable for 2020 are as follows:

- **3 consultant vacancies**: Those eligible for nomination are those who are on the specialist register and are Fellows by Examination or Fellows ad eundem
- **0 anaesthetist in training vacancies**: There are no trainee vacancies this year
- **0 SAS vacancies**: There are no SAS vacancies this year.

Information for those standing

Consultant members of Council are elected for a maximum of two terms and an aggregate of ten years. The first term of office is six years and, subject to re-election, the second term is up to four years. Terms of office can be extended if a Council member becomes a president or vice president, subject to the maximum terms of those offices.

The 'Duties and Responsibilities of Members of Council' can be found at: bit.ly/Councilduties. All those wishing to be elected to Council are asked to read this document prior to seeking nomination.

Timetable

- **22 July 2019**: nominations open via our election website: www.ersvotes.com/rcoa20
- **30 September 2019** at 12.00 noon: nominations close. All completed nominations must be received on the online platform by this date and time. Any nominations received after this date will not be accepted.
- **30 September 2019**: members' ballot contact details finalised. Fellows and members who have changed their email address are requested to give notice to the membership team by emailing subs@rcoa.ac.uk by this date to allow time for updating.
- **16 October 2019**: announcement of candidates standing. The names of the candidates will be published on the College website.
- **30 October 2019**: ballot emails distributed. Ballots will be sent electronically by ERS to the email address registered at the College. The ballot process will be managed and verified by ERS.
- **2 December 2019**: election closes at 12:00 noon.
- **3 December 2019**: result announced. The election results will be declared via the College website as soon as possible following the ballot count. The results will also be published in the president's e-newsletter and the College *Bulletin*.
- **11 March 2020**: new members will be admitted to their first council meeting.

Contact Information: Rose Murphy, CEO Office Manager, Telephone: 020 7092 1612 or Email: ceo@rcoa.ac.uk

Guest Editorial

CANNABINOIDS: WHERE ARE WE?

Dr Sanjay Bhandari
ST5, Leeds General infirmary
West Yorkshire

Dr Rajesh Menon
Consultant in Anaesthesia and Chronic Pain,
Calderdale and Huddersfield NHS Trust

There has been plenty of recent publicity regarding the medicinal use of cannabis,[1] particularly around children being denied access to medicines containing cannabinoids and also around their use for long-term pain problems. Some cannabis containing products have been rescheduled, and since November 2018 can be prescribed, with certain limitations, in the UK. A 2018 report by BDS Analytics (who provide data related to the cannabis industry) estimates that the legal cannabinoids market could be worth $57 billion globally by 2027.[2]

An initial review by the Chief Medical Officer concluded there was evidence that medicinal cannabis has therapeutic benefits. The Advisory Council on the Misuse of Drugs (ACMD), which carried out the second part of the review, recommended that specialist doctors should be able to prescribe medicinal cannabis provided those products meet safety standards.[3] The ACMD also recommended that cannabis-derived medicinal products should be placed in Schedule 2 of the Misuse of Drugs Regulations 2001 (drugs with high potential for abuse which may lead to severe psychological or physical dependence, such as opioids and ketamine). These drugs are subject to the full controlled drug requirements relating to prescriptions, safe custody and the need for a controlled drug register.

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The ACMD will be conducting a long-term review on the medicinal use of cannabis, and the National Institute for Health and Care Excellence (NICE) has been commissioned to provide advice for clinicians by October 2019.[3] The government will monitor the impact of the policy closely as the evidence base develops, and review the policies when the ACMD provides its final advice.

The situation is complex, with two products containing cannabinoids already having product licenses – nabilone (a synthetic form of tetrahydrocannabinol (THC)) for PONV associated with chemotherapy, and nabixomols (a 50:50 mixture of THC and cannabidiol in a spray form for mucosal absorption) licensed for use in spasticity in multiple sclerosis, although not supported by NICE.

A licence for Epidiolex (cannabidiol) is likely to be issued shortly for its use in certain resistant epilepsies in children.

The prescribing of other products under the new guidance is for substances that have no licence.

The situation for long-term non-cancer pain is complex. The statement of the FPM[4] indicated that the evidence base at present is too weak, on both safety and efficacy, to recommend the use of cannabinoids. This view is supported by the Royal College of Physicians and the British Pain Society. Less restrictive guidance from the European Pain Federation, indicated that it 'should only be considered by experienced clinicians as part of a multidisciplinary treatment'.[5]

There is considerable public enthusiasm in the area of pain management, with many viewing cannabinoids as a definitive answer. This sounds very similar to the issue of opioids being used for patients with chronic pain, and here we are in the middle of a worldwide epidemic. The evidence for cannabinoids indicates that some of the most consistent effects are their adverse effects, especially in the cannabinoid naïve patient.[6] The oral forms often have erratic absorption, whereas the inhaled form leads to rapid increases in plasma levels which may lead to intoxication, and addiction. Also, patients with chronic pain may benefit from sustained release rather than rapid increases and decreases.[7] There is some evidence of benefit in patients with neuropathic pain[8] but good quality trials are needed to confirm this.

All the above may result in increased use of cannabis, and for us as anaesthetists and pain physicians this may have implications for our practice. With further research, the pressures and possible indications are likely to increase. Anaesthetists may see more patients on medicinal cannabis, and will need to understand the various interactions between anaesthetic drugs and cannabinoids. Further research with the use of cannabis is very important if we are not to find ourselves in a similar position to the current opioid situation, where the adverse effects of using them are significant and accompanied by high addiction potential. We also need technologies to tease out THC from the hundreds of other chemicals to improve the safety profile of the medications.

More patients with chronic pain will have questions about cannabinoids, and it is important that good quality patient-orientated information is easily available. The various societies, namely RCoA/Faculty of Pain Medicine, Association of Anaesthetists and the British Pain Society, are already taking a lead role in disseminating information for doctors so that they are better informed and can help patients to answer their queries and help in further research. As the research base improves we will get a clearer picture, and, if and when clear therapeutic indications are recognised, guidelines will probably be formulated, and the current legal restrictions on prescription for cannabinoids by general practitioners may be relaxed. But until then, the prescription can only be by specialists, and should be in the context of multidisciplinary teams when a decision is made.

As more patients are prescribed cannabinoids and long-term reviews are conducted by ACMD and NICE, we hope to get a clearer picture regarding the effectiveness, indications, adverse effects and the addiction potential of the various cannabinoids.

Watch this space.

References

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3 Further advice on scheduling of cannabis-derived medicinal products *ACMD* (bit.ly/2FhxXYp).
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8 Mücke M *et al*. Cannabis-based medicines for chronic neuropathic pain in adults. *Cochrane Database of Systematic Reviews*. 2018(3).

Dr Barry Miller
Dean, Faculty of Pain Medicine

Faculty of Pain Medicine (FPM)

Be seeing you

'And the sky, full of stars'
J M Straczynski

This is my final piece as Dean of the Faculty of Pain Medicine – by September there will be a new person in the post and I wish them all the best. It is a great position and gives a unique perspective to the profession: I am already envious of my successors.

Royal Colleges and their faculties are evolving bodies, taking the demands of the profession and the environment in which they practise, and aiming to make it all work better in some way, and to set it up to meet the unknown challenges of tomorrow and beyond.

Over the last few years we have worked to improve the franchise to include acute/inpatient practitioners, and so help to develop educational and professional materials. This also nicely slipstreams with the new Centre for Perioperative Care (congratulations to Dr David Selwyn – see page 31 for more information) and we are looking to welcome non-anaesthetic secondary-care practitioners in the near future.

We also face external fragmenting pressures from the 2012 Health & Social Care Act, and, more recently, from concerns over the issues of opioids, cannabinoids, gabapentinoids, and other interventions.

We are placing ourselves as the principal professional body, looking at our therapeutic role in national conversations with government, NICE, MHRA and others. To complement this locally, it is important for fellows to reach out to CCGs, GPs and secondary-care colleagues with educational messages, which it is clear they are often looking for.

My final words are simply a big thank you to Daniel Waeland (Head of Faculties), Emmy Kato-Clarke (Manager), Claire Driver, Laura Owen and Anna Ripley. These are the people who work behind the scenes to make the faculty work, and who email, encourage, cajole and ring me to get things done. As with any organisation, it is the multidisciplinary team that makes it work, not one individual.

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Dr Peter Hersey
Chair, FICM Education Sub-Committee

Faculty of Intensive Care Medicine (FICM)

FICM education

The FICM has recently decided to set up an Education Subcommittee (ESC) to expand its educational activities. By the time this article is published it will have met for the first time and will, we hope, be hard at work.

At first much of the activity will be behind the scenes, but we hope it will not be too long before we launch a collection of high-quality, open access educational resources. The idea is not to replicate the excellent FOAM (Free, Open Access, Medical education) resources already available, but to particularly highlight the work of the faculty and address any specific needs or requests of fellows and members.

The ESC will also oversee continued development of e-Learning for Intensive Care Medicine (e-ICM: www.e-icm.org.uk). Current areas of development include:

Learning paths

Learning paths are collections of the most useful sessions for a particular topic or need. Two of the new learning paths address the curriculum-mapped needs of ACCS and core anaesthesia trainees in ICM.

New content

Following a successful bid for funding from Health Education England, we have started work on new sessions. Sessions currently in development include maternal critical care, decision-making and admission to critical care and induction of anaesthesia in the critical care unit.

Revision of content

We launched e-ICM with much shared content from several other e-Learning for Healthcare programmes. This has left us with some sessions that we are unable to update, and some areas where the content isn't as specific as we'd like. The ongoing revision of ICM content in e-LA is helpful, but we are aware of more areas in need of 'refreshment'. Where possible we are updating sessions, but if that's not possible new content will be produced in due course.

Allied Health Professional engagement

We are about to start work on ensuring that e-ICM is useful for the whole critical care team by producing new content and creating more learning paths.

Dr Kirstin May
RCoA SAS Member of Council,
Horton General Hospital, Banbury

SAS and Specialty Doctors

IN PRAISE OF APPRAISAL...

'Being interested is more important than being interesting'
Ann Landers

My colleague Lucy Williams and I have held a number of SAS meetings and engagement sessions since we joined Council in 2016 and 2015 respectively. We will continue to hold these, alongside educational events, as part of our role. If you haven't met us yet, please come along to one of these events, or approach us individually.

We are often told that in some hospitals SAS doctors are not encouraged to take on non-clinical roles. Often doctors themselves are not sure if they are 'allowed' to be clinical or educational supervisors, appraisers, rota-masters, etc, or sure what skills or qualifications are required. Sometimes concern is expressed over the time commitment required, particularly in a climate of reducing SPA time. Some colleagues want to expand their roles, and indeed their horizons, but wait for opportunities to come to them rather than actively seeking or even demanding them.

I often recommend becoming an appraiser.

My personal experience

Before becoming an appraiser, I had many years of experience as an appraisee myself. During the early days of revalidation I represented SAS doctors in a local policy group for implementation, so I was already very well informed.

Personally, I have had a multitude of appraisers and diverse experiences over the years. Some of my appraisers were consultant colleagues who knew me well, and some were relative strangers. I usually felt I benefited the most from appraisals with senior anaesthetists who knew me well, and always came away with good suggestions and ideas, and relevant feedback. One of my appraisers was even from a different specialty, as in my trust appraisal is organised on a cross-specialty basis. Years ago I even had a traumatic experience with an appraiser who knew nothing about my clinical skills and competence – I work in a large multi-site organisation – but seemed to have a mindset doubting the competence of an SAS doctor from the start.

I was invited by my trust's appraisal lead to become an appraiser approximately four years ago.

Initial training was provided in a small group setting by a commercial training company. All other attendees were consultants, mostly not known to me. Considering that all attendees had many years of experience as appraisees, the training was quite basic and the trainer without any clinical background. Most of the limited benefit was derived from discussing difficult potential scenarios among ourselves. In contrast, the ongoing support from my trust is very good, with regular appraiser network meetings and an excellent annual clinician-led training day. Ongoing CPD focuses on potential difficulties, pitfalls and challenges.

After initial training I was supplied with a list of appraisees. Our local agreement stipulates 10 appraisals per appraiser per year. Allocations are made regardless of grade, resulting in me having to appraise an eminent academic as one of my first interactions. Over the last few years most of my meetings have been with consultants, with a few specialty doctors or clinical fellows thrown in.

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What is difficult?

The most challenging aspect is attempting to understand the details of the professional lives in other specialties. Most of my meetings have been with pathologists and radiologists, which limits understanding of continuous professional development, incidents or complaints. On the other hand, it is interesting to learn how other specialties think differently, for example in benchmarking individual performance.

The administration of appraisal has become significantly easier since my trust introduced an online appraisal system. There is no longer the need to bounce new versions of large documents backwards and forwards, only to find the inbox full. There used to be an appraisal season in the spring, causing diary difficulty, but we have worked hard to spread appraisal timings across the calendar, which is a significant improvement.

I have not had any difficulty with consultants openly objecting to an SAS appraiser. Sometimes one senses surprise when contact is first made, but so far that has been easily overcome. One doctor that I have never met asked for a different appraiser to be allocated for a spurious reason, though the grapevine told me that the individual objected to an SAS appraiser.

What's in it for me – and potentially for you?

This is the most uplifting aspect of my job, alongside obstetric anaesthesia. I am always thrilled to get an in-depth view of someone else's professional life. This often extends into their private life with surprising candour. Over the course of three consecutive years, plans and aspirations – professional and private – can really come to fruition and difficulties can be overcome. It makes me realise how many highly motivated and enthusiastic people work in the NHS. Background, age, seniority, and specialty – they all vary, and that makes it fascinating. Appraisal meetings always leave me with a spring in my step and grateful for the many amazing people giving their best every day!

'Every human is like all other humans, some other humans and no other human'
Clyde Kluckhons

Dr Douglas Justins
RCoA Chair, Senior Fellows and Members Club

SENIOR FELLOWS AND MEMBERS CLUB

The Senior Fellows and Members Club met at the College on Tuesday 28 May 2019. This was the first meeting fully organised by the new team of Emily Worth and Ewelina Kolaczek from the Membership department. In addition, the caterers were new. As expected everything went very well indeed.

Thank you to Ann Ferguson, who has compiled the 'What to do in London list' attached to the programme for many meetings.

The President, Ravi Mahajan, highlighted the leadership that the College is showing in the field of perioperative care. The CEO, Tom Grinyer, gave a detailed description of College membership – now at an all-time high, and of the College's healthy financial position.

Lord Gus O'Donnell

The main lecture was delivered by Lord Gus O'Donnell, who was Cabinet Secretary and Head of the British Civil Service from 2005 to 2011. In 2010 he oversaw the introduction of the first coalition government since the Second World War. Prior to this, he was Permanent Secretary of the Treasury from 2002 to 2005, and served on the boards of the International Monetary Fund and the World Bank. He was appointed to the House of Lords in 2012, sitting as a crossbencher. The title of his talk was 'Building a better nation' and he was able to draw on his wide experience, including working as Cabinet Secretary with four Prime Ministers. It was a hugely enjoyable and enlightening masterclass, mixing personal reminiscences with rational analysis of the current state of the nation. Lord O'Donnell emphasised the significant long-term savings that can be gained by early intervention in social and economic affairs and compared this to the benefits of preoperative interventions in anaesthesia.

The autumn meeting will be held in Liverpool on Thursday 7 November 2019. The topic will be 'Burma Railway Medicine', and the lecture will be given by Professor Geoff Gill from the Liverpool School of Tropical Medicine. After the Second World War, the LSTM cared for a large number of Far East POWs, and it possesses a vast fund of information about the diseases suffered by the prisoners and the miraculous feats performed by the doctors and dentists who were also POWs. By coincidence, in a nearby art gallery, there will be an exhibition of painting done in secret by the Far East POWs.

The autumn meeting will be held in Liverpool on **Thursday 7 November**.

Chris Kennedy
RCoA CPD and Revalidation Coordinator

Revalidation for anaesthetists

Updated guidance for CPD event providers

For a number of years the College has been offering a CPD approval scheme for courses and events which is based on overarching criteria set by the Academy of Medical Royal Colleges (AoMRC). The criteria appear in the AoMRC document '*Standards and criteria for CPD activities: a framework for accreditation*', which has recently been updated; the RCoA guidance for event providers has been modified in response to this.

Many doctors will attend or participate in CPD activities run by regional, national or international providers, and these will be selected and judged appropriate by the doctor and that judgement confirmed by their appraiser. However, the benefits of RCoA approval (for which there is no charge to NHS trusts and hospital boards, registered charities, specialist societies and associations) include the following:

- event reviews are completed by independent, specialist CPD assessors, who are clinicians experienced in the subject area. The reviews are only sent to a CPD assessor after an initial administrative check has been completed by the College revalidation and CPD team
- approved events are included and searchable in the Lifelong Learning Platform, and are also included on the College website
- the RCoA's revalidation logo, which is a registered UK trademark, can be used in the promotional material and on the delegate attendance certificates for approved events
- an annual quality assurance report of the CPD approvals process is produced which includes information on how a sample of event providers have taken action based on their delegate feedback received.

The above is underpinned by the role of the AoMRC as the national authority recognised by the European Accreditation Council for Continuing Medical Education for setting standards for the approval of CPD activities.

The guidance for event providers highlights the importance of reflection that focuses on learning outcomes and the impact on practice, and also strengthens the criteria required for reporting conflicts of interest.

With in excess of 1,000 CPD event applications being received per annum – a number which has significantly increased in previous years, we welcome new applications from doctors willing to act as CPD Assessors. For further information about this role please contact cpd@rcoa.ac.uk.

Dr Sian Jaggar
RCoA Joint AAC Lead Assessor

Dr Ewen Forrest
RCoA Joint AAC Lead Assessor

APPOINTING A NEW COLLEAGUE

One of the most important responsibilities of clinical directors is recruitment of consultants and SAS colleagues. It is also one for which they will be remembered for good or ill if problems arise later. Many aspects attract candidates to apply for posts in a particular department, including timing, departmental reputation, geography, and experiences as an anaesthetist in training. If unfamiliar with a department, one of the most important first impressions is the job description, including job plan and person specification.

Good job descriptions, like good CVs (expected of candidates), should be accurate, up-to-date and well presented.

Most HR departments have generic templates for permanent medical posts which provide trust information. This is helpful, but can lead to inaccuracies if information is not regularly updated. Anaesthetic departmental details are often cut and pasted from previously advertised posts and can be out of date. This may cause delays in post approval by RCoA Regional Advisors. The RCoA offers guidance on preparation and approval of job descriptions.[1] Submissions for approval should include post title, job plan (including timetable of commitments) and person specification, in addition to descriptions of the trust.

The post title should accurately reflect the contents of the job plan. This encourages the right candidates to the post, and reduces numbers of inappropriate applications. Posts labelled as including a 'special interest' should have a minimum of two programmed activities every week allocated to this area. Those requiring a 'specialist' should have a minimum of three PAs per week.

Job plans should have a timetable showing all expected commitments. It is in everyone's interests for a job plan to contain at least three regular sessions, allowing new colleagues to build relationships, confidence and a reputation with theatre teams. Advertising a completely flexible job plan may be unattractive to candidates, potentially implying that 'anyone will do'. Moreover, it fails to demonstrate what a department really wants from a prospective colleague (apart from a bum on a seat!). Any person specification for such a post will inevitably be very generic.

There is little detailed advice on writing a good quality person specification to accurately reflect what is required of a prospective colleague. This is unsurprising as needs vary, but providing specific requirements aids applicants and helps in shortlisting and the making of robust decisions at interview. In general the person specification should meet these requirements:

- qualifications should be specified in the first section and, for consultant posts, (prospective) presence on the specialist register
- training/abilities and experience should be covered in the next section. This is often where expressions including 'wide experience' or 'interest in' occur. These are subjective and may lead to disagreements. The curriculum provides expected levels of competence, and should be used as a guide wherever possible. This should cover both clinical and supporting professional activity domains. For example:
  - consultants covering general and maternity on-call rotas should have completed higher obstetrics training (or equivalent). Declaring on day one that they are incapable of covering an expected area of practice is embarrassing and unhelpful!
  - similarly, a specialist post containing 'an interest in' requirement should have experience detailed in terms of advanced training (or equivalent). This should probably be essential to ensure that relevant checks are included as part of the appointment process
- teaching and educational experience should normally be specified. The minimum standard for departments with anaesthetists in training should be evidence of GMC clinical supervisor recognition.[2] GMC educational supervisor recognition and local or regional teaching experience may also be desirable (or essential) depending upon the job plan, as may formal experience (eg, ALS instructor) or qualifications (eg, postgraduate certificate in medical education)
- clinical governance involvement, including audit/quality improvement, is vital to trusts' development of safe clinical practice
- management and/or leadership, including change implementation and the appreciation of resistance to change
- professional development with or without research allows trusts to appoint candidates who engage in evidence-based practice
- personal attributes/qualities/expected values of employees are increasingly specified by trusts. These are difficult to measure but are very important. Good candidates can usually provide evidence around non-technical skills, so particular requirements should be noted in the person specification
- other sections can be added to suit particular posts.

Ultimately, departments will appoint the consultants/SAS colleagues that they stipulate in their job descriptions. If specifications are basic, there will inevitably be a greater chance of inappropriate appointment. To minimise this risk, all aspects of the person specification should be SMART – specific, measurable, attainable, realistic and time-bounded (by date admitted to the specialist register).

To attract the best candidates, make the job description, job plan and person specification attractive, detailed and precise. Everyone then has clarity: the candidates of the post for which they are applying, and the department of the calibre of colleague that they expect to appoint.

References

1 Guidance for Advisory Appointments Committees. *RCoA* 2018 (bit.ly/RCoA-AAC-RA-DRA).
2 Recognising and approving trainers. *GMC* 2012 (bit.ly/2LmCLiX).

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Dr Sian Jaggar
RCoA Joint AAC Lead Assessor

AN INSIDER'S VIEW

Being an Advisory Appointments Committee assessor

More than 1,700 of our fellows and members selflessly and enthusiastically contribute their time, energy and skills to the work of the College through roles ranging from examiners and committee members, to ACSA leads and Advisory Appointments Committee (AAC) assessors. Our 2018 membership survey results showed that many more of our fellows and members would also like to get involved in the work the College undertakes.

To highlight these roles further and to provide you with a true taste of what they involve, the Membership Engagement team has created a regular series of 'Insider's view' interviews that will be appearing in upcoming *Bulletin* issues. The first interview of the series is with Dr Sian Jaggar, one of the College's AAC lead assessors. Advisory Appointments Committees are legally constituted interview panels convened by an employing body when appointing consultants or SAS doctors. The remit of the AAC is to decide which, if any, of the applicants is suitable for employment and to make a recommendation to the employing body. AAC assessors are individuals who have volunteered to act as RCoA representatives on these panels.

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RCoA: Tell us a bit about yourself. Did you know much about being an AAC assessor before you started?
Sian Jaggar (SJ): I've been interested in helping anaesthetists in training develop and achieve their dream jobs since starting as a consultant at the Royal Brompton Hospital, London. I initially felt involvement in education was the way to go. However, one of my Anaesthetists as Educators colleagues mentioned that he thought he perhaps achieved more to change trainee experience when he was clinical director. I had also developed a management exposure programme within my trust, leading me to interact with a broader range of senior people than I might have otherwise. These experiences led me to consider what help I might give anaesthetists in training if I got involved with the AAC process. I definitely saw my initial involvement as a learning experience.

RCoA: How long have you been an AAC assessor? Why did you put yourself forward for appointment as an AAC assessor?
Seven years now, and I continue to learn about the differing needs trusts have of consultants. In that sense, I definitely achieved what I had hoped for when I applied.

RCoA: Can you share any experiences, professional and personal learning, or skill sets that you have gained through your work with the College?
SJ:There is no doubt I've learnt more about employment needs, both from AAC training days and from people I meet at consultant interviews. However, I've also had the opportunity to watch and learn from a wide variety of skilled interviewers and panel chairs from many walks of life. Non-executive directors have such breadth of non-NHS (and often non-healthcare) experience that you cannot help but learn. While this is occasionally 'I wouldn't do it like that', it is more often 'what a good idea', and I take these skills back to my own trust.

However, for me, one of the most important things about working with the College is the new friends I make around the country. It is so easy to get stuck in your own little patch feeling overwhelmed by the stresses and strains of NHS work. Gaining another perspective (be it anaesthetists from other trusts, or other consultants and senior managers) brings the positive experiences that led me to my own post back to the front of my mind.

RCoA: What would you say are the important qualities an AAC assessor should have?
For me the most important thing is an interest in helping both anaesthetists in training and trusts gain the consultant colleagues they hope for. A happy, engaged department will provide great patient care – and who knows when and where my loved ones or I may need this!

RCoA: Can you share your most interesting experience from your time as an AAC assessor so far?
SJ: I think it is really important to remember that there are 'unknown unknowns' in all parts of life, and we need to plan for this – just as we would for unexpected anaesthetic events. Early in my time as an assessor I went to an interview where the department had clearly decided beforehand who they were going to appoint – a really great candidate. On the day, they were suddenly faced with another exceptional individual they hadn't had the chance to meet personally, because they had been abroad on a fellowship – flying in specially for the interview.

At interview, they suddenly realised that what they really wanted to do was to appoint both candidates. I was stumped – I hadn't faced that situation before. Fortunately, the College were on the end of the phone to help. If I could speak to the local regional advisor about whether a second (near-identical) post was appropriate, and the chief executive could confirm availability of funding, then this was not a problem. This all took time, but was achieved, providing both candidates and trust with the best outcome. As an AAC assessor, knowing that there will always be someone at the College available, and being able to be flexible oneself should the need arise, is a great help.

RCoA: If you could give one piece of advice to someone thinking about becoming an AAC assessor what would it be?
SJ: If you are interested in helping either your anaesthetists in training, or your own department or trust, this is a really good way to gain knowledge and perspective. Just do it!

We would like to thank Sian for her paticipation in this interview.

To find more about being an AAC assessor, or see what other possible involvement you can have with the College please go to the 'Get Involved' section of the RCoA website:
bit.ly/RCoA-Involved

HOW URGENT IS URGENT?

As the number of patients presenting with acute surgical problems to NHS hospitals rises, triaging patients more effectively becomes increasingly essential. This is especially true of trauma centres, where the competition for urgent access to emergency theatres is most contested.

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) is an organisation based in London whose purpose is 'to assist in maintaining and improving standards of care for adults and children for the benefit of the public'. In 2004 they created a system for classifying urgency of surgery into four groups (Table 1).

Many NHS trusts use the NCEPOD system; however, this only allows for three basic emergency surgery classifications. A local audit demonstrated that the NCEPOD codes were poorly understood by surgeons and that there were inconsistencies in the code used when booking cases of a similar urgency. Queen's Medical Centre in Nottingham has sought to generate its own classification to provide greater granularity to the triaging process. This resulted in the creation of the Nottingham Urgency Codes (Table 2) in 2014, which expanded the number of categories from three to eight by defining urgency as the amount of time in hours within which surgery should be performed.

A key benefit of the Nottingham Urgency Codes lies in their simplicity. There is a universal understanding of what the code means, which results in cases being booked with an appropriate urgency code, and the increased number of categories assists the theatre co-ordinator and lead anaesthetist in prioritising emergency cases.

The codes provide a benchmark against which we can audit our emergency theatre

Table 1 NCEPOD urgency codes

	Category	Description	Time frame	Example
1	Immediate	Immediate life, limb or organ-saving intervention – resuscitation simultaneous with intervention	Normally within minutes of decision to operate	Life-threatening gastrointestinal bleed
2	Urgent	Intervention for acute onset or clinical deterioration of potentially life-threatening conditions for those conditions that may threaten the survival of limb or organ, for fixation of many fractures, and for relief of pain or other distressing symptoms	Normally within hours of decision to operate	Perforated bowel
3	Expedited	Patient requiring early treatment where the condition is not an immediate threat to life, limb or organ survival	Normally within days of decision to operate	Developing large bowel obstruction
4	Elective	Intervention planned or booked in advance of routine admission to hospital	Timing to suit patient, hospital and staff	Resection for non-obstructing carcinoma

Table 2 Nottingham Urgency Codes

Code	Time period from booking to theatre	Priority indication
Urgency 1	1 hour or less	Immediate life-threatening urgency
Urgency 3	3 hours or less	Unstable, with risk to life OR organ/limb threatening urgency
Urgency 6	6 hours or less	Stable, but risk of early decompensation OR early risk to organ/limb
Urgency 12	12 hours or less	Stable Risk of early deterioration in surgical problem if left untreated
Urgency 18	18 hours or less	Stable Risk of deterioration in surgical problem if left untreated
Urgency 24	24 hours or less	Deterioration in surgical problem not expected within 24 hours
Urgency 48	48 hours or less	Deterioration in surgical problem not expected within 48 hours
Urgency 96	96 hours or less	Deterioration in surgical problem not expected within 96 hours

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Dr Donna Chatterton
CT2 ACCS Anaesthetics
Queen's Medical Centre,
Nottingham

Dr Ben Lowe
CT2 Anaesthetics,
Queen's Medical Centre,
Nottingham

Dr Andrew Hutchinson, Consultant Anaesthetist, Queen's Medical Centre, Nottingham
Dr David Evans, Consultant Anaesthetist and Anaesthetic Lead for Emergency Theatres, Queen's Medical Centre, Nottingham

workload over time, both in terms of relative urgency code frequency (Figure 1) and weekly breach rates, allowing us to track the relationship between capacity and demand (Figure 2). The codes can also be aggregated with standard NCEPOD codes for national reporting and comparisons with historical records.

The Nottingham Urgency Codes have received positive feedback from both surgeons and anaesthetists who are new to the trust, and have also received praise from ACSA (Anaesthesia Clinical Services Accreditation) on their recent visit. As our departments get busier and resources become stretched further, we believe that it is vital that there is an effective and auditable triage system to ensure that our patients receive timely care. The Nottingham Urgency Codes provide a simple system to allow this.

Figure 1 QMC emergency cases by urgency code

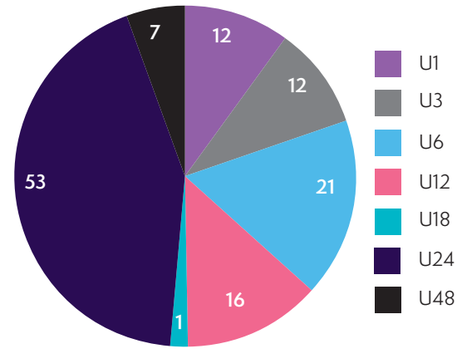
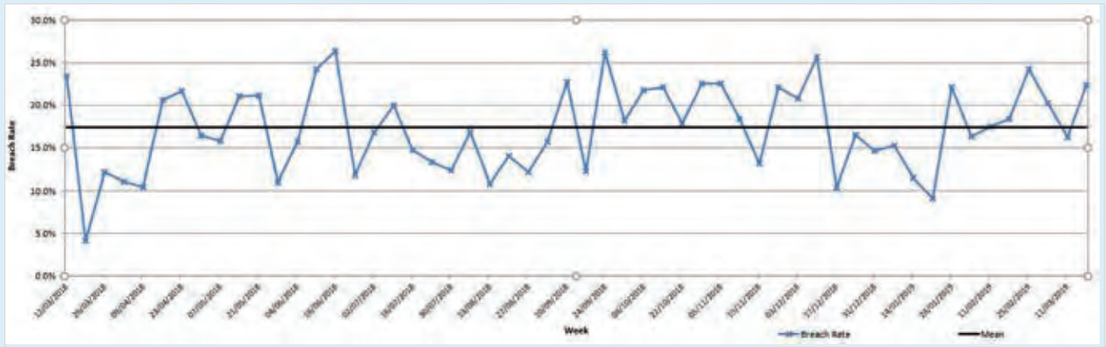


Figure 2 QMC emergency breach rate



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1 National Confidential Enquiry into Patient Outcome and Death. (www.ncepod.org.uk/classification.html) (accessed 27/01/2019).
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The Perioperative Medicine Clinical Trials Network

The POMCTN three years on

In June 2016, shortly after the announcement of Brexit, the *Bulletin* featured an article introducing both the implications of Brexit for healthcare and the future for perioperative medicine clinical trials. While the government has failed to deliver a strategy for Brexit and the future of the United Kingdom, the Perioperative Medicine Clinical Trials Network (POMCTN) has done quite the opposite, delivering on a strategy which has facilitated and supported high-quality clinical trials in perioperative medicine.

To date, the POMCTN has supported the recruitment of more than 2,000 patients to trials, and has also grown to have more than 300 local and principal investigators, hosted five successful national conferences, launched a chief investigator mentoring scheme, and is gaining an increasing profile on social media.

Background to the POMCTN

An estimated 340 million people undergo surgery worldwide each year. Complications after surgery are common, and these can result in significant delays in patient recovery and return of functional independence, and can increase longer-term mortality and consume significant resources. As the population ages and more patients are expected to have surgery, improvements in perioperative care may have a substantial impact on wider public health. The Royal College of Anaesthetists responded to this challenge by launching the concept of

Attendees at the POMCTN meeting in Birmingham May 2019 – members and board members

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Dr Ramanathan Kasivisvanathan
POMCTN Board Member
Head of Anaesthesia and
Perioperative Medicine
The Royal Marsden London

Dr Joyce Yeung
POMCTN Deputy Director
Consultant in Anaesthesia and
Critical Care, Heart of England

Perioperative Medicine (POM). POM will however require a robust clinical evidence base, and large clinical trials will be a primary source of evidence defining the optimal approach to POM. In 2015, the National Institute of Academic Anaesthesia decided to form a clinical trials network (CTN) to develop, support and coordinate world-class trials in perioperative medicine in the UK. At the time of conception, few major trials were being conducted in anaesthesia and perioperative medicine either in the UK or worldwide when compared to other specialties such as cardiology and oncology.

The research supported

The POMCTN supports research projects involving the recruitment of patients where the aim is to improve outcomes following surgical treatment. The primary focus will be on large clinical trials (≥ 500 patients). New CTN projects are selected from proposals made by the members of the network.

Examples of trials we currently support are listed on our website www.pomctn.org.uk/Trial-Selection-Process,

Case-study of a POMCTN trial

FLOELA (Fluid Optimisation in Emergency Laparotomy) – a large pragmatic multicentre clinical trial that aims to find out whether cardiac-output-guided haemodynamic therapy given to patients during and shortly after emergency bowel surgery saves lives compared to usual care. The trial is being run in more than 100 UK hospitals, and has already recruited an incredible 1,308 patients!

What does the POMCTN mean to you?

The aim of the CTN is to allow anyone of any relevant professional background and level with an interest in perioperative care to make a meaningful but realistic contribution to clinical trials and observational studies in perioperative medicine. These follow two main ways of doing this:

Become a local investigator or principal investigator

Join either the POMCTN local investigator (LI) scheme (currently 182 members) or the principal investigator (PI) scheme (currently 134 members). The aim is that all investigators will be active on at least one CTN-adopted study, either as an LI or PI. New members are able to apply to join either scheme from the CTN website www.pomctn.org.uk. To be a CTN member you will need to provide basic evidence of research readiness, such as a Good Clinical Practice certificate, and you will need to renew your membership every two years. Investigators will be given a much greater sense of ownership of projects, many of which will have been developed as new ideas within the network and will be led by members. There are at least two meetings each year to ensure that members are the first to hear about development projects and about the full-scale trials we will need help with.

Chief investigator scheme

The chief investigator scheme provides training and mentorship for a small number of talented individuals who wish to lead their own clinical trials in perioperative medicine. Applicants will be existing members of the POMCTN LI or PI scheme with a proven track record of recruitment to clinical trials, and ideally will have experience of a complete research cycle as a grant co-applicant from outline application through to publication and dissemination of results.

Use the POMCTN as an educational resource

Should you not wish to become a POMCTN member, the website (www.pomctn.org.uk) is still a useful resource for everything related to perioperative medicine clinical trials in the UK. The POMCTN has its own twitter feed (pomctn@pomctn twitter.com/pomctn), which is curated by a different member every two weeks. Output from the feed focuses on perioperative research and meetings, as well as on clinical trial updates. The two-yearly POMCTN meetings also provide general training on research-related issues. This year's meeting at Birmingham focused on seeking consent in clinical trials. The days are competitively priced for both members and non-members.

PERIOPERATIVE JOURNAL WATCH

Dr Katie Samuel, ST7 Bristol School of Anaesthesia; Dr Maxine Okello and Dr Kon Lon Shum, Perioperative Medicine Fellows, University College London Hospitals

Perioperative Journal Watch is written by TRIPOM (trainees with an interest in perioperative medicine – www.tripom.org), and is a brief distillation of recent important papers and articles on perioperative medicine from across the spectrum of medical publications.

Enhanced Recovery after surgery (ERAS) program for lumbar spine fusion

Smith J *et al*. *Perioperative Medicine* 2019

This US study implemented an ERAS protocol for 96 patients undergoing one- or two-level lumbar spinal-fusion surgery. The ERAS bundle included perioperative multimodal analgesia, early mobilisation and physical therapy postoperatively, and prophylactic anti-emetics. Pre-ERAS and post-ERAS data were studied to analyse compliance with the bundle and postoperative outcomes.

A significant decrease in the incidence of postoperative nausea and vomiting (40 to 24%), along with long-term opioid use, was found in the ERAS group (14.6 to 5.2%; p = 0.025). Compliance with ERAS was mixed, with postoperative interventions being particularly poor. Problems such as limited physiotherapy staff coverage were identified as affecting postoperative mobilisation and therefore length of stay. The institution did however note that patients were better prepared for surgery, as there were fewer surgical delays and improved patient optimisation before their operation.

Antithrombotic therapy after acute coronary syndrome or PCI in atrial fibrillation

Lopes RD *et al*. *N Engl J Med* 2019;380:1509–1524

There is no clear international consensus guideline identifying optimal choice of antithrombotic for patients with atrial fibrillation (AF) who then proceed to develop an acute coronary syndrome (ACS) or undergo primary coronary intervention (PCI). This large international trial recruited 4,614 patients with AF and recent ACS or PCI. They were randomised to receive either apixaban or vitamin K antagonist (VKA), with either aspirin or placebo for six months using a two-by-two factorial design, with all receiving a standard P2Y12 inhibitor.

Bleeding was less common with apixaban compared to VKA (10.5% vs. 14.7%; p<0.001) and more common in aspirin compared to placebo (16.1% vs. 9.0%; p<0.001). Apixaban had a lower incidence of death or hospitalisation than VKA (23.5% vs. 27.4%; p=0.002), with similar incidence of ischaemic events in both groups. The authors support the use of apixaban with a P2Y12 inhibitor without aspirin in this cohort.

The impact of preoperative intravenous iron on quality of life after colorectal cancer surgery: outcomes from the intravenous iron in colorectal cancer-associated anaemia (IVICA) trial

Keeler *et al*. Anaesthesia 2019;74:714–725

This follow-up study used data from the intravenous iron in colorectal cancer-associated anaemia (IVICA) trial – a multicentre, randomised, non-blinded study randomising anaemic patients to receive either intravenous or oral iron prior to colorectal cancer surgery. The authors aimed to compare quality of life (QoL) scores between the groups. A number of different QoL measures were assessed, along with haemoglobin level, in 116 patients – at recruitment, immediately before surgery, and at outpatient review approximately three months postoperatively.

The intravenous iron group were found to have significantly increased QoL scores between recruitment and surgery as well as in postoperative clinic, along with higher haemoglobin levels at each stage. There was a significant correlation found between increasing haemoglobin and changes in QoL scores.

Perioperative outcomes of bariatric surgery in the setting of chronic steroid use

Mazzei M *et al*. *Surg Obes Relat Dis* 2019

Steroids treat many chronic diseases, but can predispose to surgical complications. This US study was a retrospective, 1:1 propensity-score and case-control matched analysis of 302,140 patients who underwent sleeve gastrectomy or laparoscopic gastric bypass for weight loss, using the MBSAQIP database; 4,554 patients (1.62%) were on chronic steroids or immunosuppressive drugs.

Patients using steroids were older and had significantly higher rates of co-morbid conditions, but once propensity and case-control matched, steroid use was not found to be an independent risk factor for poorer outcomes (length of stay, intensive care unit admission, re-operation, re-admission, bleeding, infectious complications), except for an increased rate of leak. The authors therefore concluded that bariatric surgery is safe in patients with chronic steroid use, provided co-morbidities are appropriately managed.

The College is committed to developing a collaborative programme for the delivery of perioperativecare across the UK: **www.rcoa.ac.uk/cpoc**

Centre for Perioperative Care

In 2014 the RCoA launched its vision for *Perioperative Medicine: the pathway to better surgical care*. Five years on, we have developed this vision through updated curricula, standards, and building our network of local perioperative leads and innovators. Now we take the next step with the formation of a multidisciplinary centre to drive the integration of patient care in the UK.

CPOC is a partnership between:

Royal College of Anaesthetists

Royal College of Surgeons ADVANCING SURGICAL CARE

Royal College of Physicians

Royal College of Nursing

RCGP Royal College of General Practitioners

Association of Anaesthetists

WHAT IS CPOC AND WHY NOW?

Professor Ravi Mahajan, RCoA President

In 2014, the College articulated its vision for perioperative medicine as being the integrated multidisciplinary medical care of patients, from the moment of contemplation of surgery until full recovery. It was envisaged that this would meet the 'triple aim' of improving patient experience (including quality of care and satisfaction), improving the health of populations (including returning to home/work and quality of life), and reducing the per capita cost of healthcare.

Recent data from a number of studies and sources, including that from the Perioperative Quality Improvement Programme (PQIP) and the National Emergency Laparotomy Audit (NELA), confirm the potential of integrated perioperative care in meeting the triple aim. It is now clear that this concept needs to be turned into reality in all NHS hospitals in the UK.

In the autumn of 2018, I met with the presidents of the Royal Colleges of Surgeons, of Physicians, of General Practitioners and of Nursing, and the Association of Anaesthetists; they all offered immediate support to the RCoA in the establishment of a mutidisciplinary Centre for Perioperative Care (CPOC). I also received immense support from many other organisations, including specialist societies, and from the chief medical officers of all the devolved nations, the NHS England medical director, the national director of patient safety, and special advisors to the prime minister and the secretary of state. The RCoA council and I are extremely thankful to all of them for their timely, crucial and important support for CPOC.

In the month of May this year, CPOC was launched and its director appointed. The Centre, with its board drawn from a number of partner organisations, has already embarked on a number of workstreams, including standard setting, training curriculum, professional education, quality improvement, and research and policy development in relation to perioperative care within the UK.

Healthcare systems worldwide face the challenges of multimorbidity, changing population dynamics, and limited resources. The triple aim of CPOC will prepare us for the challenging times ahead. I am certain that, with the support of our fellows and members and of the partner organisations, CPOC will emerge as a world leader in guiding the implementation of integrated perioperative care for surgical patients.

Dr David Oliver (Clinical Vice-President, Royal College of Physicians), Professor Ravi Mahajan (RCoA President), and Professor Denny Levett (President, Perioperative Exercise Testing & Training Society) at the CPOC launch at Anaesthesia 2019

Centre for Perioperative Care

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NEW CPOC DIRECTOR

Dr David Selwyn, CPOC Director

I am delighted to have been appointed as the inaugural director for the Centre for Perioperative Care (CPOC). Working currently as the deputy medical director for Nottingham University Hospitals NHS Trust, I combine a significant leadership/managerial role with undertaking clinical duties as a consultant in anaesthesia and adult critical care for 50 per cent of my time.

My leadership journey began when I became a College tutor, and then the East Midlands regional advisor, a role that I held for eight years before being appointed as head of service and lead clinician following a merger between two Nottingham NHS trusts. During my time as head of service, clinical director, and subsequently divisional director, I have delivered a number of high-value capital and service change/quality improvement projects, which included the innovative vanguard radiology technology consortium – EMRAD – recently adopted as an artifical intelligence testbed.

CPOC represents a unique opportunity to promote, advance and develop perioperative care. This will involve cross-organisation, cross-specialty working and relationships and the changing of patient pathways and integration of services through a multidisciplinary team approach. We will build on the substantial work delivered through the perioperative medicine leads and PQIP, and develop a clear three-year strategy to deliver CPOC with realistic deliverables and realistic timelines. At the core of this will be delivery across the three dimensions – improving the quality of healthcare, improving the health of the population, and achieving value and financial stability. Initially this will focus on developing the five PQIP improvement opportunities – diabetes and anaemia, individualised risk assessment, enhanced recovery, individualised pain management, and drinking, eating, and mobilising (DrEaMing).

However, for me the real excitement about CPOC is the opportunities that it presents to really improve the perioperative journey for our patients, to change outcomes, and potentially to improve all of our working lives. It also offers the opportunity for anaesthesia to work with all the myriad of stakeholders across all four 'home' nations – patients, surgeons, physicians, GPs, nurses, and allied health professionals – and to lead this development to deliver tangible outcomes and results.

How will we gauge the success of this project? I think this will be about having grasped those opportunities to improve quality patient care with transformational change, best practice, and helping patients help themselves. At the same time the opportunity to develop new training and workforce models, deliver research and innovation across a wider specialty base, and influence national and international healthcare policy around the patient perioperative pathway.

So, what could be your role in CPOC, and what are the opportunities for anaesthesia, pain management and ICM? Hopefully, this issue of the *Bulletin* will encourage and inspire you to get involved in the programme. There will be much more released over the coming months, but in order to achieve this ambitious project I have a series of 'asks' of you – I ask that you have a commitment to listen, that you are bold in your thinking, that you ensure that your voice is heard, and that you play your part to help shape the future. There will be a series of leadership roles within and around CPOC that you may wish to get involved in, but I would also like to hear your views on where you see the opportunities to take CPOC forward.

While I cannot promise that every proposal will be adopted, I can promise that your suggestions will be read and considered. Email: cpoc@rcoa.ac.uk.

We are now recruiting for a CPOC Deputy Director – see page 60 for more details.

THE FUTURE OF PERIOPERATIVE CARE – LAUNCHING CPOC

CPOC was launched at the College's flagship 'Anaesthesia 2019' event in May 2019. As part of the event, a panel was held on the future of perioperative care. It was an excellent and engaging discussion, the main points of which are captured below. It should be clearly noted that the exchanges have been edited and condensed for presentation here – and some opening comments on the *Game of Thrones* series finale excised entirely!

The panel was moderated by Professor Monty Mythen, former RCoA Council member. The panelists were Professor Mike Grocott (RCoA Vice-President), Ms Celia Ingham-Clark (Medical Director for Professional Leadership and Clinical Effectiveness, NHS England), Dr David Oliver (Clinical Vice-President, Royal College of Physicians), Professor Ravi Mahajan (RCoA President), and Professor Denny Levett (President, Perioperative Exercise Testing & Training Society).

Monty Mythen (MM): **To begin, where do we think postoperative morbidity ranks with regard to disease burden and the so-called 'silver tsunami'?**

Mike Grocott (MG): The perioperative journey is the third-biggest contributor to mortality after heart attack and stroke – around 7–8 per cent of all mortality. The volume of surgery worldwide is going to rocket upwards, so that burden will also go up. But data suggests there is a substantial modifiable component.

MM: **What do we think are the big challenges?**

Celia Ingham-Clark (CI-C): I think there are three: the increasing range of procedures available due to technological advancements, the increasing co-morbidity of patients and the challenge of optimising and recovering them, and issues around expectation.

MM: **Where does the challenge of different 'tribes' come in?**

David Oliver (DO): Look at the transformation of hip-fracture care in the last 10 years through a tripartite drive between surgeons, physicians and anaesthetists. However, we do need to remember the limitations in physician numbers. We have to think about upskilling other members of the workforce. How can we get more people doing the right thing at the right time?

MM: **How can we address the inequity of access to high-care environments postoperatively?**

Denny Levett (DL): We need to develop integrated risk-evaluation models. The risk predicts the outcome – we find CPET useful to predict both high- and low-risk cohorts. Is the model of 'intensive care or ward' what we need, or something more appropriate for an elective, planned cohort?

MM: **One of the concerns we hear from anaesthetists regarding perioperative care is that they will be out on the wards doing everybody else's work.**

Ravi Mahajan (RM): As long as we think about things as everybody else's work, we will not be able to integrate the pathways in the way that patients require. Good quality care will actually create time for us to be more preventive

'You need to have a concept of the entire pathway, not be an expert in every part of it' – Professor Denny Levett

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Panel discussion at Anaesthesia 2019

MM: **Are we letting surgeons off the hook?**

CI-C: If I'm the surgeon doing an anterior resection in theatre, I cannot look after a patient on the ward at the same time. The traditional assumption that my house officer could do that and I could later catch up with them is not good enough. It needs to be a team approach.

MG: The underlying question here is about competency. There are clearly areas where surgeons or geriatricians are the most knowledgeable. What is important is that the pathway is properly managed.

RM: Traditionally the anaesthetist mindset is of the one-man band. We need to be an orchestra.

DL: From experience of running a perioperative service, being the 'middle man' is actually incredibly useful. You need to have a concept of the entire pathway, not to be an expert in every part of it.

DO: People want an all-rounder who can deal with all the co-morbidities and get advice when they need it – that one person who can be the co-ordinator rather than lots of people thinking in their silos.

RM: We are there to look after patients, not think in silos. We need to understand better what happens outside the hospital. More day-to-day GP interaction, sharing knowledge and decisions.

DL: We need to work out what we are asking GPs to do – they are keen to engage but overwhelmed. We need to work out specific referral pathways and improve the evidence base.

MG: Possibly the biggest thing we can do is address the question of 'wrong surgery'. Provider bias means that if you put a service in, more operations take place.

CI-C: The thinking until recently has been that if you are in a provider organisation you need to maximise your income with procedures. In new 'integrated care systems', commissioners and providers agree to work together to save money, reducing the incentive for inappropriate operations.

MM: **From the floor – should perioperative medicine become its own specialty?**

MG: I think not: this would rip the guts out of anaesthesia. I don't think all anaesthetists have to be perioperative physicians, but I think it's important that 'team anaesthesia' stays heavily involved in perioperative medicine.

RM: We are on a journey. Five or six years ago, people were concerned about whether this was the right way to go, but now they ask how to get there. CPOC is part of the vision for how that can be implemented.

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WHO ARE THE CPOC BOARD?

The inaugural CPOC Board was set up to reflect the overarching ethos of perioperative care – that of truly multidisciplinary, multi-organisational collaboration. You've already met the Director of CPOC, Dr David Selwyn on page 31. Here we introduce the rest of the CPOC Board and they expain in their own words why now is the right time for the new Centre.

DR LIAM BRENNAN, CHAIR

Liam Brennan is a consultant anaesthetist at Addenbrooke's. A major theme during Liam's term as RCoA president (2015–18) was his commitment to the perioperative movement, putting the anaesthetist at the heart of delivering and coordinating the safest, highest-quality, and most cost-effective care for individual and population benefit.

'I am delighted to chair the Centre for Perioperative Care at such an exciting time, when this vision for the future of our specialty is resonating not only with anaesthetists but with other healthcare professionals and national and international healthcare policy makers.'

PROFESSOR MIKE GROCOTT, VICE-CHAIR

Mike Grocott is the Professor of Anaesthesia and Critical Care Medicine at the University of Southampton, and Consultant in Critical Care Medicine at University Hospital Southampton. Mike was recently elected vice-president of the RCoA, commencing in September 2019. He chairs the board of the NIAA, was founding director of the Health Services Research Centre (2011–2016) and chaired the National Emergency Laparotomy Audit (2012–2017).

'The Centre for Perioperative Care is bringing health and care professionals together to improve the care of people having surgery, enabling the perioperative care team to deliver the best possible care and improve our patients' surgical experience.'

JENNIFER DOREY, LAY REPRESENTATIVE

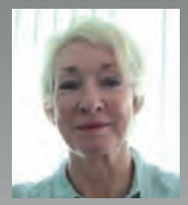
Jennifer Dorey was a practising hospital pharmacist for most of her career, including 20 years as chief pharmacist in a large teaching hospital and pharmaceutical advisor to a strategic health authority. She is a member of the boards of the NIAA, the Perioperative Medicine Clinical Trials Network, the HSRC Patient Carer and Public Involvement Group, and the PQIP project team.

'I am very excited to be part of this aspiration to achieve a truly partnership approach, putting patients and their families at the centre and valuing and maximising the contribution from all health care staff and others involved in their journey.'

DR KATHLEEN FERGUSON, PRESIDENT, ASSOCIATION OF ANAESTHETISTS

Kathleen Ferguson is a consultant anaesthetist at Aberdeen Royal Infirmary. She has been a College tutor and regional advisor, and is a Final FRCA examiner. Kathleen has served as honorary treasurer for the Association, and has chaired the Finance, Audit and Investment Committee and the Safety and Standards Committees.

'The patient's surgical pathway has until now been characterised by frequent hospital visits, punctuated by encounters with a myriad of healthcare professionals. CPOC will change this experience for the better, for both patients and staff. The Association of Anaesthetists embraces this concept and looks forward to delivering on this exciting advance in patient care.'



SUSAN HILL, VICE-PRESIDENT, ROYAL COLLEGE OF SURGEONS

Susan Hill has been a consultant vascular surgeon at University Hospital Wales since 2003. During her career, she has been a clinical director, vascular advisor for Wales, chair of the National Statutory Advisory Group to the Welsh Assembly, training programme director, and chairman of the Welsh Board of the RCS.

'The Royal College of Surgeons is pleased to collaborate with the RCoA in what is a ground breaking multidisciplinary partnership. The CPOC aspires to optimise an individual's physical and psychological preparedness for surgery, and hasten their recovery and return to a full life following their operation.'

DR SARAH CLARKE, CLINICAL VICE-PRESIDENT, ROYAL COLLEGE OF PHYSICIANS

Sarah Clarke, an interventional cardiologist, is the immediate past president of the British Cardiovascular Society. She is the clinical director for strategic development at Royal Papworth Hospital, a Joint National Lead for Cardiology for the NHS's Getting it Right First Time (GIRFT) programme and a trustee at the British Heart Foundation.

'The RCP is fully committed to furthering the cause of perioperative care. Today's inpatient and outpatient population is older, often living with multiple long-term conditions. A team-based, interdisciplinary approach is essential to improve care processes and outcomes'.

DR JONATHAN LEACH, HONORARY SECRETARY, ROYAL COLLEGE OF GENERAL PRACTITIONERS

Jonathan Leach is a GP in Bromsgrove, Worcestershire, and the NHS England Medical Director for Armed Forces and Veterans. He has been instrumental in the design and delivery of the new models of care for veterans. In addition to the above, Jonathan is joint honorary secretary of the Royal College of General Practitioners (RCGP).

'Working with and alongside hospital and other colleagues is important for General Practitioners and the wider primary care team. The RCGP supports CPOC as an approach to improve services to patients, and especially to ensure that patients are cared for to high standards.'

LAWRENCE MUDFORD, PATIENT REPRESENTATIVE

Lawrence Mudford has had a 38-year healthcare career working as a dentist and dental educator within both primary and secondary care. This has included serving on the board of the Faculty of General Dental Practice and as a member of the General Dental Council.

'The NHS Long Term Plan recognises the need for an integrated healthcare approach focused on a "shared responsibility". CPOC is timely and welcome, as it allows the patient's journey to be central and at the heart of personalisation of care.'

SUMAN SHRESTHA, ROYAL COLLEGE OF NURSING

Suman Shrestha is a consultant nurse in critical care at Frimley Health NHS Foundation Trust and the Royal College of Nursing Professional Lead for Acute, Emergency and Critical Care. He is a qualified advanced critical care practitioner. He leads the Perioperative Care Forum of the Royal College of Nursing (RCN).

'Perioperative nursing is dynamic and continually evolving to meet the changing needs of our patients. The RCN welcomes the opportunity to collaborate on improving the holistic care we deliver to our patients and the support we provide to all staff working in this setting.'

DR MIKE SWART, ROYAL COLLEGE OF ANAESTHETISTS

Mike Swart works at Torbay Hospital in Devon. He has been involved in the development of perioperative medicine locally and nationally for more than 20 years, and is the joint clinical lead for anaesthesia and perioperative medicine for the NHS GIRFT programme.

'I believe anaesthesia is preoperative, intraoperative and postoperative care: anaesthesia is perioperative medicine and perioperative medicine is anaesthesia.'

IMPROVING QUALITY OF CARE

Professor Mike Grocott, Vice-Chair, CPOC
Dr Nicholas Levy, Lead Study Proposer, NCEPOD *Highs and Lows*

The primary theme and *raison d'etre* for the Centre for Perioperative Care (CPOC) is to improve the quality of the care we deliver to patients and thereby improve their quality and quantity of life. The principal means by which this will be achieved are the definitions of standards of care that constitute best practice in particular clinical areas, and the reliable and consistent implementation of such best-practice guidelines through the use of appropriate mechanisms: quality assurance and quality improvement. Central to these efforts will be the involvement of patients and the public at every stage.

Centre for Perioperative Care

A patient-centred approach naturally focuses on the patient journey or pathway

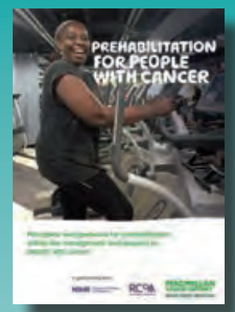
The core strength of CPOC is the multispecialty, multidisciplinary and multiprofessional foundations on which it is built. When we place our patients' best interests as the focus of our ambition, then silo-based approaches, typically based on specialty or professional boundaries, can be seen as counterproductive and irrational. In contrast, a patient-centred approach naturally focuses on the patient journey or pathway. CPOC guidelines will be pathway focused, and therefore inevitably multiprofessional and integrated (ie, involving primary, secondary and social care).

Current best practice in the development of pathway-focused guidelines (PFGs) involves a number of stages, typically including:

- definition of scope, questions and participants
- evidence synthesis
- multidisciplinary-expert-group consensus development
- grading of recommendations
- development and refinement of PFGs through iterative peer review by a multidisciplinary team.

At every stage patients and the public should be involved.

The RCoA has already embarked on this journey through the joint work being conducted with Macmillan Cancer Care and the National Institute of Health Research in developing *Principles and guidance for prehabilitation within the management and support of people with cancer*. These guidelines were launched at the third Prehabilitation World Congress in London in July 2019, and had involved three separate expert consensus groups, followed by synthesis and peer review by steering and stakeholders groups comprising more than 100 health and care professionals and patients from a broad spectrum of backgrounds. Future priorities for guidelines development include perioperative management of patients with diabetes, perioperative blood management, opioid de-prescribing, and mitigation of perioperative neurocognitive disorders.



The effective implementation of such guidelines requires the infrastructure necessary to deliver quality assurance and quality improvement. The National Emergency Laparotomy Audit (NELA) has been the prototypical example of this in perioperative care, and has achieved extraordinary improvements in the delivery of care and the observed outcomes. NELA data from the four years of published patient reports suggest that 30-day mortality has reduced from 11.8 per cent to 9.4 per cent, resulting in 700 fewer patients' deaths per year with reduced hospital length of stay (19.2 to 15.6 days) resulting in an estimated saving to the NHS of more than £34 million pounds. The Perioperative Quality Improvement Programme (PQIP), delivered by the NIAA's Health Services Research Centre at the Royal College of Anaesthetists, builds on this work and extends it to a spectrum of elective surgical procedures. PQIP has the potential to be the foundation for a universal data-collection pathway for major surgery in the UK.

CPOC has now been asked by the Academy of Medical Royal Colleges to develop guidelines to facilitate the recommendations of the 2018 NCEPOD report, *Perioperative diabetes: highs and lows*. The central theme of these recommendations is the importance of reduction of unwarranted variation that adversely affects surgical outcomes – an issue that has also been highlighted by the National Diabetes Inpatient Audits (NaDIAs), the Getting It Right First Time (GIRFT) programme and PQIP. The capacity to implement these guidelines through the RCoA's *Guidelines for the Provision of Anaesthetic Services* (GPAS) and Anaesthetic Clinical Services Accreditation (ACSA), and to monitor and drive this implementation through PQIP is an enormous asset for CPOC.

Clear descriptions of best practice in the context of patient pathways and rigorous methodical application of quality assurance and improvement methods offer great opportunities to improve the quality of care for the patients we care for day by day. CPOC offers the environment to achieve this on a partnership basis, reaching beyond the silo-based approaches that have been common in the past and promoting truly collaborative work that will benefit our patients.

SHARED DECISION-MAKING

Dr Ramai Santhirapala, Clinical Lead, Choosing Wisely UK
Professor Rupert Pearse, Director, UK Perioperative Medicine Clinical Trials Network

Shared decision-making is now a key concept for every aspect of perioperative care. There is a worldwide focus on this approach to treatment decisions, which is already a legal standard in the UK. One in three high-risk patients choosing surgery will experience serious medical complications leading to long-term decline in health and quality of life.

Awareness of these long-term risks is poor among both doctors and patients. Consequently, many high-risk patients do not receive the information they need to make an informed decision about surgery. Shared decision-making is a collaborative process between clinicians and patients, which aims to select the most suitable treatment option based on both best available evidence and informed patient preferences.

The concept of shared decision-making has been cited for decades since the US president's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in 1982.[1] However, adoption into clinical practice has been slow, particularly in perioperative care. A systematic review of decision-making in surgery, published last year, concluded that surgeons were more likely to perceive the consultation process as a shared decision than patients were, but this evidence base remains sparse.[2] Shared decision-making is an iterative process which starts from the moment of contemplation of surgery. As the role of many anaesthetists extends further across the perioperative period, this will include the decision-making process.[3]

The benefits of shared decision-making are widely recognised outside perioperative care. Patients who are effectively involved in making decisions about their care have fewer regrets about treatment, better reported communication with clinicians, improved treatment adherence, and an overall better experience with improved satisfaction. Within the UK there exists national policy on shared decision-making, with recent guidance from NHS England, the National Institute for Health and Care Excellence and the Academy of Medical Royal Colleges (AoMRC). Shared decision-making is also mentioned in international policy, such as that of the Commonwealth Fund, and is a prominent theme in the international initiative 'Choosing Wisely'.[4]

However, the challenge remains of how to implement shared decision-making, and this will be a focus of two Centre for Perioperative Care (CPOC) themes – supporting patients and research and innovation. CPOC will bring together best evidence in these areas to create implementation tools for shared decision-making in perioperative care, supported by 'Choosing Wisely UK' led by the AoMRC and the 'Optimising shared decision-making for high-risk major surgery' (OSIRIS) research programme led by Queen Mary University of London. 'Choosing Wisely UK' will focus on improving professional perceptions of shared decision-making through education and training alongside supporting patients through the promotion of four questions which explore 'Benefits, Risks, Alternatives and doing Nothing' (BRAN), with a pilot planned at Guy's and St Thomas' NHS Foundation Trust.[5] OSIRIS is a National Institute of Health Research (NIHR) funded programme which aims to explore perceptions of both patients and professionals to inform the development of specific tools to support shared decision-making. The ultimate output from OSIRIS will be a targeted intervention which solves the key challenges in the implementation of shared decision-making. CPOC is therefore playing a central role in building collaborative networks worldwide to support optimal shared decision-making for patients in the perioperative period.

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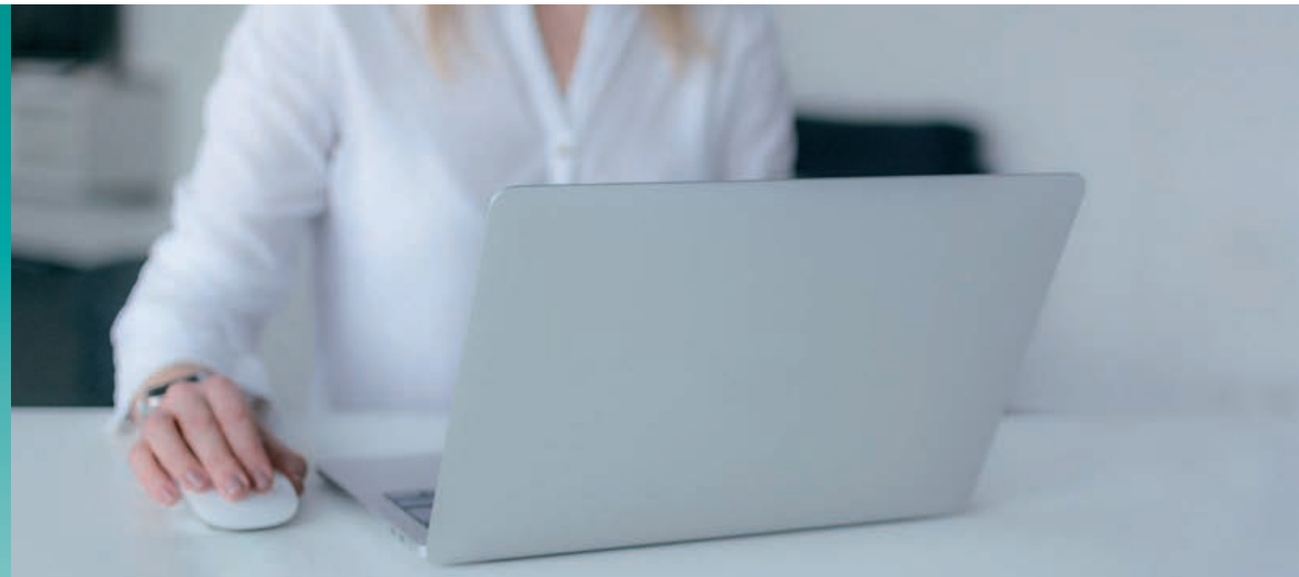

E-LEARNING FOR PERIOPERATIVE CARE

Dr Anne-Marie Bougeard, RCoA Perioperative Medicine Fellow

One of the key aims of CPOC is to support professionals from across the perioperative pathway in developing the knowledge base to underpin their practice.

In anaesthesia and pain medicine this has been provided for a number of years by e-Learning for Anaesthesia (e-LA) and e-Pain, two very successful online resources hosted by the e-learning for health (e-LfH) platform. We propose to develop a multidisciplinary e-learning resource to support a common curriculum in perioperative care. E-Learning for Perioperative Care (e-POC) will be one of the first proposed 'outputs' of CPOC, and work is already well underway.

Supporting professionals – Theme 3

Hosting e-POC on the e-LfH platform makes learning accessible to all professionals in the NHS. The current main users of e-LA and e-Pain are those starting out in these specialties and those sitting exams. E-POC will support these learners by covering the curriculum in perioperative care for anaesthetists, and will in addition, cross-reference and include other specialty curricula to allow shared and common learning across the specialties. In addition to the core learning outcomes, we will develop tutorials on areas of research and development, quality improvement and pathway change. We are working with experienced educators to develop content in the most dynamic and user-friendly way, enabling users to link their learning to online portfolios. We have already started work with TriPOM (Trainees with an interest in Perioperative Medicine), who have written tutorials for inclusion on e-POC.

Technology and digital

E-POC will feature a variety of media for the delivery of learning, in keeping with the desire of CPOC to maximise the use of digital media to support professionals. We will be developing videos, interactive presentations, animation and reflective exercises to get people thinking and talking about the challenges they face in providing high-quality perioperative care and what solutions there may be.

Watch this space for more details on the launch of e-POC. As ever, we welcome your contributions and ideas.

PERIOPERATIVE CARE IS EVERYBODY'S BUSINESS

Mark Weiss, RCoA Head of Policy and Public Affairs

I'm delighted to have joined the College as Head of Policy and Public Affairs at such an exciting time in the development of the Centre for Perioperative Care (CPOC). I've joined following seven years with the Faculty of Public Health, where I explored the role of the NHS in prevention. There are profound synergies between perioperative care and a population health approach to supporting patients to stay healthy across the life course.

The NHS Long Term Plan sets out ambitious priorities for tackling the biggest disablers of our population, including cancer and multimorbidity. But who leads? Who is accountable? Who benefits – financially and in terms of outcomes? Significant system barriers need to be overcome, from lack of integration and isolated staff, to fragmented funding and restrictive payment mechanisms. These are fundamental challenges for policy makers and clinicians.

The NHS across the UK can make the most of its patient interactions by building prevention into clinical pathways and working cross-organisationally to ensure service models are joined up. Service transformation is at the heart of securing the long-term future of the NHS, and anaesthesia-led perioperative care is a key part of the solution. If 'prevention is everybody's business', so too is perioperative care. It can help forge new links between primary, secondary and tertiary care, and support transformation of the NHS from an illness to a wellness service.

So, how can CPOC influence the NHS across the UK to realise our ambition for all surgical patients to be managed on a perioperative pathway? Over the past year we've set solid foundations. Our report, *A teachable moment,*[1] served as a valuable starting point for integrated care systems to identify how best practice in perioperative medicine can be embedded locally.

The RCoA's Policy and Public Affairs team is supporting CPOC to develop our story in a way that decision-makers find compelling. Yes, it's about having evidence on the return on investment, but we also need to model the outcomes of a perioperative pathway next year, in five years' and in ten years' time – and to communicate the benefits clearly. We need to build political and public support for policy reform by telling the personal stories behind the statistics. We will work across organisations to encourage more people (including patients) to lobby for perioperative care, and will foster champions among the decision-makers.

We have an amazing story to tell. Now more than ever we need to tell it well.

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Centre for Perioperative Care

PERIOPERATIVE CARE: THE INTERNATIONAL PERSPECTIVE

Dr Joel Symons, Anaesthetist and Head of Perioperative Medicine Education International Collaborations, The Alfred and Monash University, Melbourne

Perioperative medicine is an emerging field of medicine developing in response to the increasing age and complexity of patients and the increase in the number of surgical procedures being performed. The development of the 'silo' mentality among medical specialists has resulted in a lack of cohesiveness and a large variation in perioperative medical practice, which has led to a worldwide diversity in perioperative outcomes. This scenario had to be radically altered.

Anaesthesia has been at the forefront of this change internationally on a clinical and academic level. Evidence Based Perioperative Medicine (EBPOM)[1] has kick-started the perioperative medicine conversation among stakeholders. This has resulted in the development of the Perioperative Surgical Home in the US,[2] the inclusion of perioperative medicine in the curricula of the Royal College of Anaesthetists[3] and the Australian and New Zealand College of Anaesthetists (ANZCA),[4] and the development of the Monash University Perioperative Medicine Short Course in Melbourne and Masters' programmes in both Australia (Monash University)[5] and the United Kingdom (University College London).[6] TopMed Talk is delivering easily accessible, high-quality perioperative medicine podcasts.[7]

In October last year, The International Board of Perioperative Medicine[8] was formed to further cement the international and multidisciplinary nature of this new specialty. The Board is an international group of medical professionals who are considered experts in their respective areas of perioperative medicine. The aim of the Board is to formulate a perioperative medicine syllabus which has worldwide applicability. Furthermore, it aims to deliver and approve cost-effective education to all countries irrespective of socioeconomic status, leading to an improvement in perioperative outcomes.

The RCoA will be launching the Centre for Perioperative Care, and ANZCA is developing a perioperative medicine fellowship.

The dream of delivering cohesive, multidisciplinary, internationally consistent, high-quality care to patients undergoing surgery is slowly becoming a reality.

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PERIOPERATIVE CARE: A PATIENT'S VIEW

Lawrence Mudford, Patient Representative, Centre for Perioperative Care

Dates are very important to patients. They stand out as markers for progress, improvement and success, but also for deterioration, disappointment and decline. And they are uniquely personal to that individual.

For me, as a patient, a few stand out:

- 28 December 2016 – diagnosis results for prostate cancer
- 30 December 2016 – prostatectomy
- 12 December 2018 – two years of clear PSA results and onto yearly blood tests.

This reflection helpfully allows me to plot retrospective landmarks in my own personal journey as a patient. So, how can perioperative care support patients through the often meandering journey of hospital appointments, their understanding of decisions around risk and benefits, and the management of expectations?

From my experiences, one of the most important markers that facilitate this support is the process of shared decision-making.

Shared decision-making

The relationship between healthcare team and patient is central to perioperative care. One brings the expertise and knowledge, based on data sets, research and training; the other is an expert of their own values, beliefs and expectations. Between them, goals, options and outcomes can be managed and explored. This is particularly important when weighing up the benefits of an operation or procedure and setting them against the known risks that will be present.

Stories are powerful learning opportunities to reflect on outcomes of individual stages in a patient journey. But on their own, they are just 'stories'. The insight comes from understanding the context, recognising the resulting lessons learnt, and then deciding how to embed these experiences to provide a better patient experience for all patients. The following are real experiences from one such journey of an elderly patient:

A positive example

At diagnosis for bowel cancer, the patient was frail, underweight, anaemic, and bedridden. The perioperative pathway was well established within the hospital, allowing for a multidisciplinary approach to be underway quickly, with integration of the many departments that are needed to drive a process of prehabilitation of the patient before surgery could be considered.

As the patient responded positively to treatment, a cardiopulmonary exercise test (CPET) was discussed to assess her baseline level of fitness. This was clearly explained and a compassionate approach taken to an 83-year-old, an hour appointment being a standard timeframe for this consultant anaesthetist-led exercise. The explanation included an early warning that further tests would possibly be needed in addition to the CPET, and that a final decision for surgery may not be initially forthcoming. Thus, the patient's expectations were met at an early stage. The exercise was intensive but took account of her frailty, and the testing was successfully completed. With additional testing at a second appointment, it was explained that although the patient's level of fitness was borderline, the anaesthetists were confident to recommend surgery.

A less-helpful example

Following successful colorectal surgery for bowel cancer, it was suggested to the same patient that there may be a small additional benefit in having a six-week course of chemotherapy to deal with any cells that had 'escaped' during surgery. Unsure of what to do, and still frail three weeks after surgery, she sought advice from the district nurse who was attending to support homecare stoma management. The strong suggestion from the nurse was that 'as you have done so well with the surgery, it would be a shame not to have chemo as well.' While this advice was given in good faith, it was directive, didn't take into account an older patient's full needs at that time, and led to the patient expressing to family members a feeling of guilt if she did not agree to the additional treatment.

This was obviously not a good illustration of shared decision-making for the reasons discussed above. When the patient attended her consultant oncologist appointment a week later, the risks and benefits were fully discussed (a rise of life expectancy over five years from 85 per cent to 90 per cent) along with a full explanation of the treatment procedure and side effects. The patient was able to make a more balanced, shared decision, and opted not to have the chemotherapy.

So, how can we positively critique these experiences?

Centre for Perioperative Care

The NICE website describes the benefits of shared decision-making as:

- both those receiving and those delivering care can understand what is important to the other person
- people feel supported and empowered to make informed choices and reach a shared decision about care
- health and social care professionals can tailor the care or treatment to the needs of the individual.

There are many factors that lead to empowerment of patients in decision-making, coupling the skills, experience and research available in a modern NHS care pathway with patients' wishes and expectations.

A symbiotic relationship will always benefit patient outcomes. A positive appreciation of the role of all parties involved in perioperative care is therefore the answer to all of the questions that arise to guide a successful patient journey.

Addenbrooke's CESR programme: supporting SAS anaesthetists

Currently there are more than 2,000 SAS anaesthetists working in the UK. This includes clinical fellows, specialty doctors, associate specialists, and locum consultants. To be able to apply for consultant positions in the UK these doctors need the Certificate of Eligibility for Specialist Registration (CESR). There is a rigorous application process for anaesthetics – demonstration of such equivalence currently requires 800–1,000 pages of evidence.[1]

It is well recognised that as a specialty we need to do more to secure our future anaesthetic workforce. Two recent reports published by the Royal College of Anaesthetists highlight the workforce potential for our local Specialty and Associate Specialist (SAS) doctors.[2,3] SAS doctors make up twenty-two per cent of our workforce. Ninety-five per cent of them do not have CESR. The majority are not planning to apply for CCT training posts. About a third are struggling with evidence collection for CESR within their current jobs. The reports also highlight SAS doctors' disenchantment with the current system for career progression, and a need for assistance in achieving this.

At Addenbrookes in February 2018, we conceptualised the idea for initiating a CESR programme, while discussing ways to balance helping these doctors and securing a stable workforce. As a tertiary centre for neurosurgery, we regularly receive requests from SAS doctors for modular training. These doctors face specific challenges posed by the current visa system (limiting their release from the base hospital), and the need to deliver service (especially out of hours in the

Dr Ahmed Elrefaey
Locum Consultant Anaesthetist,
Addenbrooke's and Rosi Hospitals, Cambridge University Hospitals NHS Foundation Trust

Dr Amit Prakash, Consultant Anaesthetist, Dr Rowan Burnstein, Consultant in Anaesthesia and Intensive Care and Dr Hemantha Alawattegama, Consultant Anaesthetist, Addenbrooke's Hospital, Cambridge University Hospitals NHS Foundation Trust

base hospital) while achieving training in another trust.

These issues are not confined to the neuroanaesthetic element, so a structured modular programme would be needed. Fortunately, all of the required experience, apart from cardiac anaesthesia, could be addressed within our trust.

In March 2018, along with the East of England head of school for anaesthesia, we held a stakeholder meeting to agree on the structure, requirements and timelines for the programme. It was decided that the targeted candidates would have to be fairly senior and qualified, as we were not going to build a programme that replaced training delivered by Health Education England, but given the strict requisites for application and the stipulation for experience to be evidenced for CESR in the preceding five years, a three-year modular programme was configured.

The primary concerns were funding and incorporating a cardiac rotation. The latter was sorted by formulating a service level agreement (SLA) with the Essex Cardiothoracic Centre. This agreement obviates the need for a new visa application which is expensive and time consuming.

Shortages for on-call cover in the anaesthetics departments due to recruitment and workforce retention issues is a problem faced by trusts across the country, especially in middle and junior grades. We retrospectively reviewed our expenditure on current fellows, not in training positions, and registrars in training locums for on call, and put forward a business case for the programme. This included salaries, funding and time for educational supervision and assessment, and appropriate study leave for the fellows. The funding was secured by redistributing resources within the department and no new investment was necessary.

We now have a programme which mirrors GMC and RCoA requirements for CESR equivalence, including non-clinical components such as audits, participating in research and opportunities for developing leadership and management skills.

The objective is for successful candidates to undergo a three-year CESR fellowship, with dedicated educational supervision and annual assessments (Annual Review of Competency Progression) to ensure they have appropriate training and evidence to submit a successful CESR application. They would be expected to use the Life Long Learning Platform (LLP) to manage their training portfolios. They would train alongside the local anaesthetists in training (including undertaking appropriate on-call activity), and the two programmes would be organised to ensure CESR programme training did not impact on the quality of training for National Training Number (NTN) holders (and vice versa).

In October 2018 the fellowship was advertised on national websites. We received 120 applications from which we made a long list of 61 GMC-registered applicants with FRCA or equivalent qualification who were working in the UK as SAS doctors. There were a large number of high-quality applicants, making the process very competitive even at the shortlisting stage. We devised a points-based scoring system to ensure that the shortlisting process was fair. Eventually 11 applicants were invited to the interview in November 2018, and four out of these were appointed to start in February 2019.

We aim to receive regular feedback from the fellows so that we can continue to improve the programme. On successfully completing the three-year programme, all the fellows will be eligible to apply for one of our Senior Clinical Fellow posts while they await for their CESR application to be processed by the GMC.

We have realised from the number and quality of the applications received that there is great need for this kind of fellowship around the country.

We would like to thank Dr Helen Underhill and Dr Eschtike Schulenburg, our RCoA tutors; Dr Dean Frear, our clinical lead; Hannah Weeks, Lynsey Searle and Sophie Brown, our HR team; and Samantha Lear, our operational manager for the amazing team work supporting this project.

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Dr Charlotte Redshaw
ST5 Anaesthetics and ICM, Teaching Fellow,
University Hospitals of Coventry and Warwickshire

Dr Emily Pallister
ST5 Anaesthetics and Teaching Fellow, University Hospitals of Coventry and Warwickshire

Dr Eleanor Whittingham
ST5 Anaesthetics, George Eliot Hospital (former Teaching Fellow)

Mobile medical education: utilising the social media phenomenon

I remember a time before the internet existed. This is not something I share with an ever-increasing proportion of trainees. Social media became widespread in my final year at university so there have always been stories exactly how much trouble you can get in when your words are no longer wind.

On the plus side, the social media tool *WhatsApp* has created an easily accessible forum for disseminating information for trainees and consultants alike. Last year, during my gruelling Final FRCA revision period a number of us set up a revision group with one very dedicated post fellowship trainee at the helm (thank you, Ellie). We were set long-case, short-case and clinical science questions every day, and we'd all chipped in as and when we were able. We practised formulating answers, making mistakes in public, thought through tricky clinical cases and, most importantly, learning from each other's answers. I had limited opportunities for face-to-face viva practice, so I attribute my success, at least in part, to our *WhatsApp* group.

When I started my teaching fellowship, I really wanted to bring this resource to all trainees in our school and luckily my fellow teaching fellow, Emily was also a graduate of the original group. We signed up all the interested parties to a group rather imaginatively named 'Viva Practice' and recruited a faculty (who all belong to 'Viva Faculty') to spread the burden of formulating questions. This included Ellie, another trainee from the original group and one who didn't really know what she was letting herself in for. The format changed from the original group, and the malleable nature of our forum both in its organisation and its participation means that things will certainly be different again for the next group. We have had enthusiastic participation from the candidates who have signed up so far, and of the ten candidates across both groups there has been a 100 per cent pass rate. We need more time to gather data but are feeling rather pleased with ourselves currently!

The benefits go deeper than the ones we have discussed so far. By the time most of us sit the Final FRCA our lives are so busy with partners, children and mortgages, as well as with a full-time job, that it is vital that every opportunity we find for revision must be of maximum benefit. However, the most recent pedagogy has shown how ineffective the revision techniques employed by most of us actually are. Up to 70 per cent of what is heard in a lecture or read in a book is forgotten within a few days and repeated reading produces fluency with a text more than long-term memory of a subject.[1]

There are several pedagogical ideas that have been proven to maximise retention of information.

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- Active recall interrupts forgetting, strengthening and multiplying the neural routes for retrieval. Mini tests on material being learnt can improve retention up to 50 per cent more than reading alone, and is known as the testing effect.[1] Testing also has the benefit of calibrating what you do and do not know to guide further study.
- Mixing up your learning rather than massed practice or block learning encodes memory into higher orders of the brain and can improve final performance by up to 215 per cent.[1] It impedes performance during initial learning but time between periods of learning allows memories to consolidate. The increased effort of recall on return to the subject creates stronger memory compared to easy immediate recall. Essentially, it may feel more effective to go over the Vaughan-Williams classification until you can recite it perfectly, but it is encoded into short-term memory and won't be assessable three months later in the exam without further consolidation. The time is used more efficiently if it is divided up.
- Dialogic teaching uses discussion to empower a learner to explore the limits of their understanding, as well as using language as a tool for constructing knowledge. This is based on Vygotsky's 'zone of proximal development'[2] which is the knowledge that can be achieved through small logical steps from basic principles to something previously unknown. It promotes comprehension rather than rote learning.
- It is more beneficial to attempt to reach your own solution to a problem (even if it is incorrect) rather than just memorising a provided solution.[1] Generation improves retention and gives a firmer basis to hang the new ideas on.

The *WhatsApp* group's fluid nature readily utilises all these ideas and active participation daily is a high-impact, low-effort revision method. I won't claim that we extensively researched our idea; it was more that we stumbled upon something that worked and that subsequent reading has provided evidence to back up our ideas. Emily and I plan on starting a primary group next with the help of the rest of our faculty as well as by press ganging all those that pass into becoming new faculty members.

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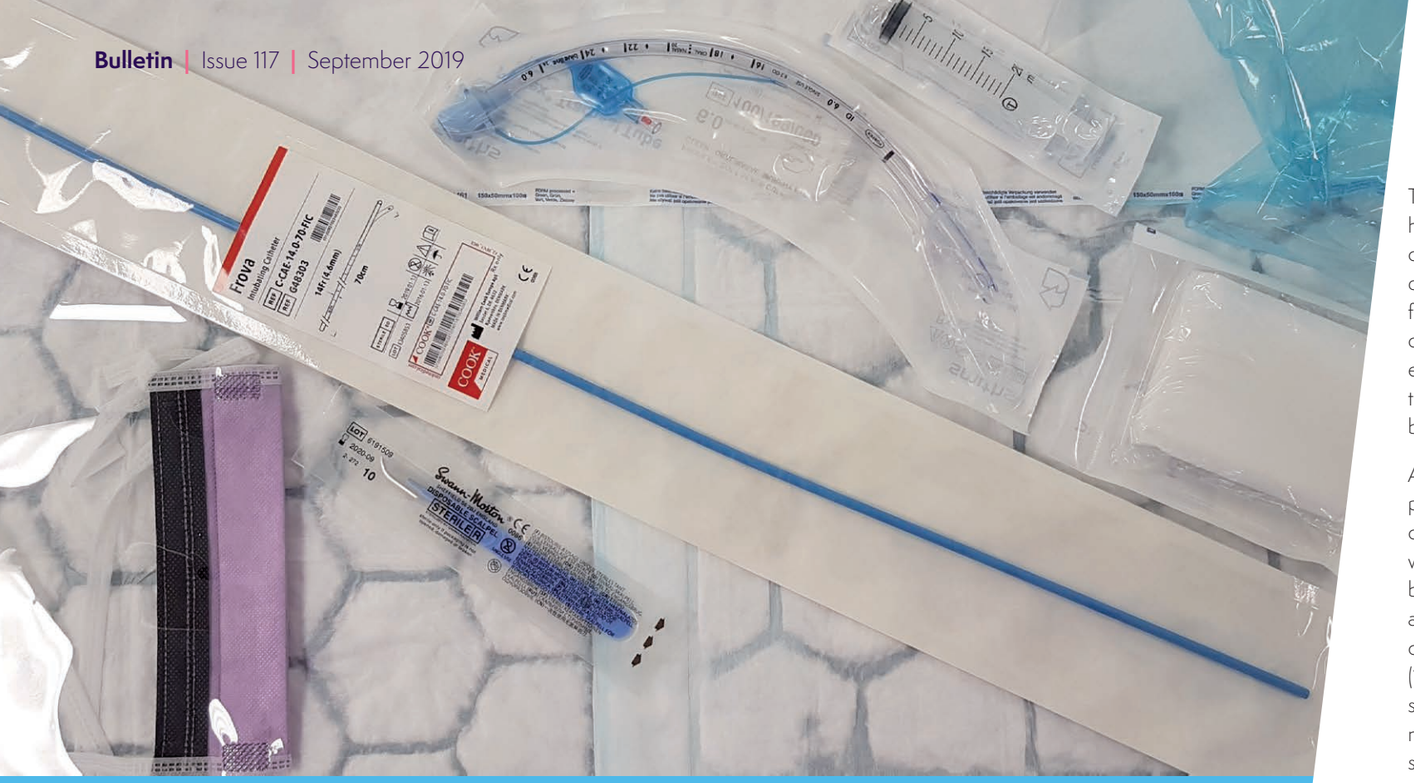

Jon Pearce
Senior Operating Department Practitioner, Brighton and Sussex University Hospitals NHS Trust

Dr Abhijoy Chakladar
Consultant Anaesthetist, Brighton and Sussex University Hospitals NHS Trust

Jay McDonald, Senior Operating Department Practitioner, Brighton and Sussex University Hospitals NHS Trust
Dr Merle Cohen, Specialty Registrar in Anaesthesia, Brighton and Sussex University Hospitals NHS Trust
Dr Sandeep Sudan, Consultant Anaesthetist, Brighton and Sussex University Hospitals NHS Trust

‘Plan-D’ kits: an innovative emergency solution

After attending the first World Airway Management Meeting in Dublin in 2015 and learning of the new Difficult Airway Society guidance for utilising a scalpel technique for performing emergency front of neck access (eFONA) in a Can’t Intubate Can’t Oxygenate (CICO) scenario, we adopted it as the technique of choice at our institution.[1] This required a change in equipment and training.

Traditionally, airway trolleys at our hospitals varied in appearance and content and, from experience, people did not know the equipment required for eFONA or its location. We were concerned that low familiarity with equipment would contribute to failure to manage CICO and represented a barrier to transitioning to eFONA.[2,3]

A team led by operating department practitioners (ODPs) decided that a pack containing the necessary equipment was required, and investigated how to best create and present these for use in airway crises. We decided the optimal contents were an intubating catheter (‘bougie’), size 10 scalpel, 20ml luer slip syringe, size 6 cuffed tracheal tube, mask with eye protection, and gauze swabs. Our sterile-services department agreed to package the equipment in supplementary wrap to create a simple, tear-open pack (see image 1). We aimed to place these in every anaesthetic room.

By August 2016, we had successfully placed these packs in wall-mounted catheter holders in every one of the Trusts 30 anaesthetic rooms and by the start of 2018 they were included in the Plan-D drawer of our new, standardised, difficult airway trolleys. Packaging costs were only £0.30 per pack, and they have a shelf life of three years. The low cost enabled us to place kits in every critical care unit, the emergency department, anaesthetic emergency grab bags and other remote areas. In March 2018, we conducted a survey of all anaesthetists to test knowledge of equipment for eFONA and its location: 88 of 138 anaesthetists responded and 98 per cent were aware of the equipment required for eFONA and its location. ODPs and anaesthetists now routinely discuss airway plans A to D for every patient during the pre-anaesthesia time-out, and we have located small laminated DAS prompt cards for performing scalpel cricothyroidotomy near every pack.[4]

Image 1 Plan-D kit in holder

Our ‘Plan-D’ packs are visible, are used in training, and demystify the CICO and eFONA processes, aiding both psychological and physical transitioning. We believe easily locatable, standardised equipment that match guidelines, together with the provision of cognitive aids and their use in training, improves transitioning and is an enabler in the management of airway emergencies.[2,3] This is further consolidated by integrating the airway plan into the briefing. As the contents are already stock equipment, the packs are near to cost-neutral. These kits, with their low additional cost (£0.30) and their small form factor have proved to be an elegant solution for placing eFONA equipment in every conceivable area that airway interventions may be carried out in the trust.

We have successfully implemented a simple, effective, and cheap ODP-led solution. The Plan-D packs are reproducible at any hospital and have already been implemented in the theatre complexes and emergency grab bags at King’s College Hospital, London by one of the authors (MC). We are keen to share our experiences with colleagues nationally and internationally, and would encourage colleagues everywhere to replicate this process. If you would like to find out more please email: abhijoy.chakladar@nhs.net.

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The packs cost only 30p to make and are small enough to put anywhere you might give an anaesthetic

Dr Borys Topor
ST6 Anaesthesia,
University Hospitals Plymouth
NHS Trust

Regional anaesthesia: an alternative international perspective–Switzerland

It is recognised that appropriate overseas experience is beneficial to UK-based training,[1] and detailed information and guidance is available from the Royal College of Anaesthetists.[2] Organising a year abroad might be challenging in terms of time, money and family commitments, and might not be always achievable. Shorter periods as a clinical observer, on the other hand, might also be of benefit, as I discovered during my two-day placement at one of Switzerland's leading regional anaesthesia centres, the Balgrist University Hospital.

For anaesthetists in training inspired to complement their UK training in regional anaesthesia, it is possible to arrange a short visit to European centres through the European Society of Regional Anaesthesia (ESRA). I discussed my prospective visit with Dr Nicholls, an educational supervisor in one of my previous rotations (Taunton), and we came to the conclusion that a short observer placement would be most beneficial. Advantages of an arrangement like this are that little paperwork is needed and the time off work can be easily arranged as routine study leave.

Unfortunately, without local or national registration there is little chance of hands-on experience, but observing experts in their own environment is often better than struggling under guidance, and is very instructive. In my case, I applied directly to Professor Eichenberger at the Balgrist University Hospital, and was kindly invited to visit the hospital as a clinical observer. I chose Switzerland as I have some familiarity with the culture and language.

From a logistical point of view, familiarity with the proposed place and its language and culture makes things easier. It is useful to identify the best time to visit to fit in with your training as well as with the hosting team.

While on the placement it was beneficial to adopt a flexible and balanced approach. For example, during times when there was no immediate clinical case to observe, I managed to learn about local service provision procedures, and the structure of training and the healthcare system.

The Balgrist University Hospital in Zurich is a specialised orthopaedic hospital focused on elective procedures. There are six operating theatres, and the team is performing more than 5,500 orthopaedic surgical procedures each year, most of which are done under regional anaesthesia with sedation. There are three anaesthetic nurses and two anaesthetists allocated to every two lists. Once surgery starts, the first nurse looks after the patient while the anaesthetist is going through the notes for the next day's cases. The next patient arrives in the anaesthetic room about 40–60 minutes before their procedure to allow time for the block to be performed without delay, and is looked after by the second nurse. A senior anaesthetist supervises all six theatres, and is available for help and advice, as well as chairing the daily afternoon meeting where all the next day's cases are discussed.

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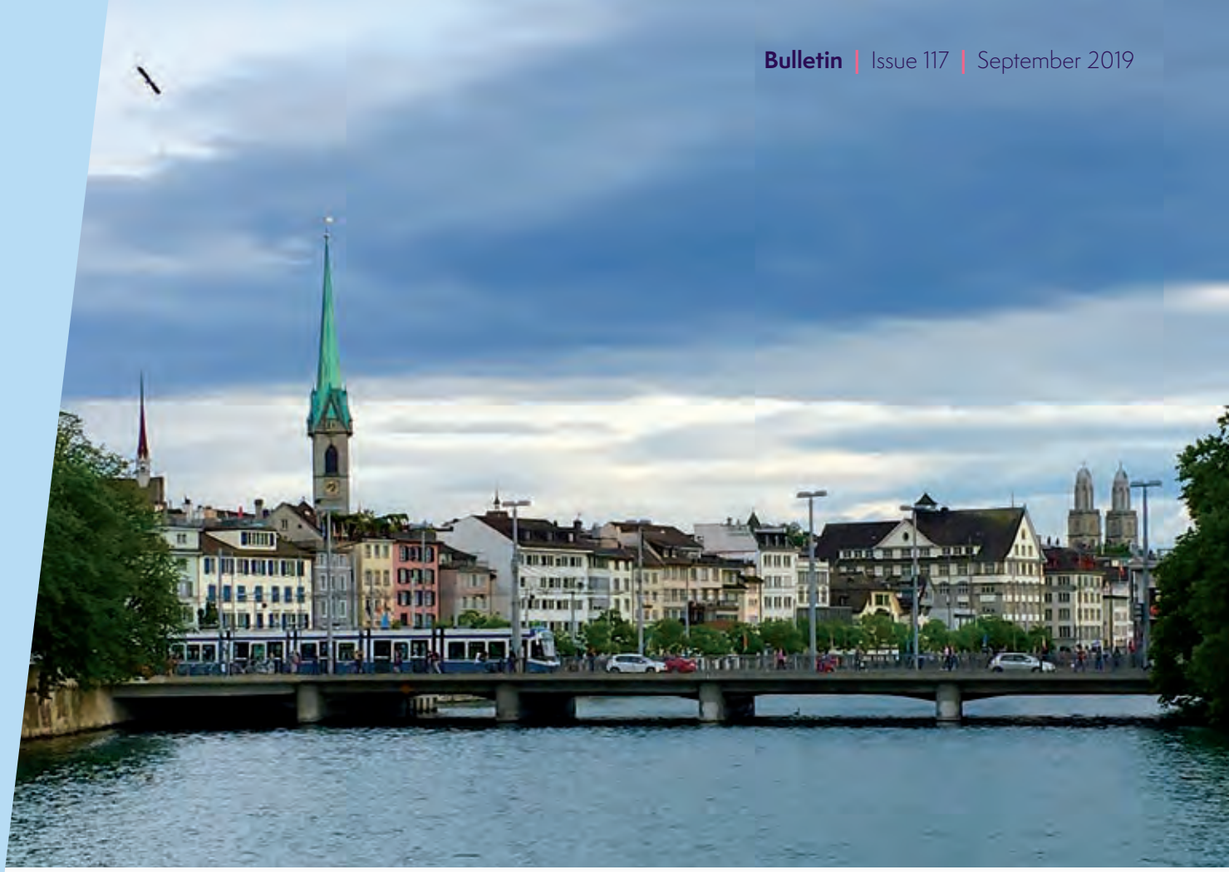

Zurich, Switzerland

The acquisition of skills in regional anaesthesia for anaesthetists in training is structured as stepwise learning related to the complexity of the block technique. The anaesthetist in training starts by performing a low-risk block, eg, axillary, and gradually progresses to interscalene catheter placement. Usually, regional anaesthesia training placement is for six months, and provides the anaesthetist in training with the logbook records of 150–250 blocks together with catheter placements.

Access to the healthcare system in Switzerland is arranged through mandatory health insurance, which is compulsory and cannot be turned down by insurers when the citizen applies. There is a high degree of choice, and care can be accessed directly at all levels. Public satisfaction with the system is high, and there are generally no waiting times for being seen/treated by a specialist. Total health expenditure is 11.5 per cent of GDP (compares with 9.8 per cent for the UK in 2015).[3]

In summary, I found my observership placement a useful and exciting experience. It certainly broadened my understanding of regional anaesthesia practice as well as providing ideas for service improvement back in the NHS, such as an extended role for anaesthetic practitioners in regional anaesthesia list management, and a more structured approach to skill acquisition for regional anaesthesia. Naturally, it was not without challenges, such as the short duration of the visit, absence of hands-on practice, and the fact that some acquired experience might not be transferable to the UK healthcare system due to differences in culture and tradition.

I am very grateful to Dr Barry Nicholls, Consultant in Anaesthesia and Pain Management at Taunton, and Professor Urs Eichenberger and the Anaesthetic Team at the Balgrist University Hospital for their kind help, time and valuable advice during my visit.

Also, it would be wrong not to mention the kind support of my family!

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College Tutors' Meeting 2019

Poster competition winners

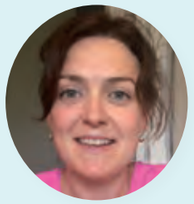
At the recent College Tutors' Meeting in Chester, the submissions for the annual Poster Competition were judged. The three highest-scored abstracts were selected for oral presentation at the meeting. Dr Deborah Sanders was awarded first place, with Dr Laura Oakley in second place, and Dr Arran Marriott in third.

1

Anaesthetic Bootcamp – a springboard to success

Dr Deborah Sanders and Dr Beatrice Charlesworth, ST7 Anaesthetics, Severn Deanery
Dr Lorraine Alderson and Dr Kate Holmes, Consultant Anaesthetist, Plymouth Hospitals NHS Trust

Dr Deborah Sanders
ST7 Anaesthetics,
Severn Deanery



Dr Beatrice Charlesworth
ST7 Anaesthetics,
Severn Deanery

When novice trainees commence anaesthetic training, it can be daunting and challenging for trainees as well as trainers. 'Anaesthetic Bootcamp' was developed in order to ensure that all novices are armed with the core skills, baseline knowledge and confidence that they need before going into theatre. It can be challenging for trainees to gain core anaesthetics competencies, confidence and capability within the required timeframe.[1,2] This course acts as a springboard for the trainees, facilitating an efficient and positive start to their learning.

Bootcamp is an innovative one-day simulation course for novice anaesthetic trainees. It was developed and delivered by specialist trainees with consultant support, and a standardised, comprehensive training pack has been created.

In anaesthesia, trainees usually work with seniors rather than fellow trainees. During Bootcamp, we deliberately utilise peer-to-peer training to enhance learning, promote group-dynamics training, and to help build the wide support network that is essential in maintaining morale.[3]

The Bootcamp course learning objectives include: preoperative assessment, airway management, and emergency drug preparation. We used questionnaires to score clinical confidence before and after the course. Feedback from the initial courses was overwhelmingly positive. Confidence scores in pre-assessment increased 129 per cent, 46 per cent in airway management and 123 per cent in preparation and planning. Other feedback showed that the specialist trainee-led teaching was very useful and confidence building. The course was commended by the Specialty Training Committee, and is being introduced across the whole of the South West region.

The role of trainees as both role models and educators should not be undervalued. During the courses, the use of peer-to-peer training was clearly very effective in generating a positive learning environment. It also creates strong support networks among trainees, which are essential in building a resilient workforce for the future.

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2

Introduction of a flexible and accessible supported return to training simulation and skills day in the Oxford Deanery

Dr Laura Oakley, ST5 Anaesthesia, Dr Tamsin McAllister, ST6 Anaesthesia, Dr Phil Duggleby, Consultant Anaesthetist and Dr Katharine Francis, Consultant Anaesthetist, Stoke Mandeville Hospital, Aylesbury

Dr Laura Oakley
ST5 Anaesthesia,
Stoke Mandeville Hospital, Aylesbury

At any time between 2012 and 2017, approximately 10 per cent of the 50,000 doctors in postgraduate medical training in England were on approved time out of programme.[1] Substantial time away from clinical practice, independent of the underlying reason, can impact on the trainees' confidence and technical skills.

We identified the need for a locally accessible and flexible training day, available to anaesthetic trainees of all levels, designed to rebuild confidence in performing clinical tasks, to practise technical skills, and to address any holistic concerns they have about returning to training. We developed and introduced a regional training day for trainees who have been out of work for three months or more, and delivered a programme combining four main elements:

- **pastoral** – an opportunity to discuss problems, concerns or anxieties about returning to training with a faculty possessing a broad range of experience in the return to work process (ie, trainees who have returned to work themselves, LTFT representatives and College tutors)
- **simulation** – the chance for delegates to re-familiarise themselves with being in a clinical setting and managing a clinical scenario in a non-assessed environment
- **practical skills** – the opportunity for delegates to practise using equipment for performing common anaesthetic procedures on manikins and phantoms
- **accessibility** – a locally available course, with funded on-site childcare provision.

The specific programme was modified in consultation with the delegates in order to ensure that we were meeting their specific needs, for example, by matching simulation scenarios to the area of practice each delegate would return to. Since the primary aims included building confidence as well as redeveloping skills, debriefing was conducted in a supportive manner, free from the pressure of assessment and fostering an approach of peer support. Feedback was collected after the inaugural course in January 2019 and was extremely positive, with all delegates 'strongly agreeing' that they had learned material they would use in their role and that they would recommend the course to a colleague.

While the course is open to all trainees who have been out of training, the majority wishing to access the course are on maternity leave. This can present additional barriers to attendance, such as childcare limitations, funding and ongoing breastfeeding. Therefore, alongside the course we developed and implemented a business plan for the provision of on-site funded childcare. A mobile crèche provided on the training day was utilised by 60 per cent of the candidates, who reported that it was essential in allowing them to attend. The demonstrated accessibility benefit of the childcare scheme has led to its expansion into other specialties and regions.

The success of this initiative demonstrates that the course fulfills the objectives of building confidence, competence and technical skills when returning to training, and it will continue to be run three times per year in the Oxford Deanery.

Reference

1 Supported return to training. *Health Education England* (bit.ly/2JcBv0t).

This project was funded by the Health Education Thames Valley SuppoRTT programme

3

Fighting fatigue: the ongoing battle

Dr Arran Marriott, Dr Rob Charles, Dr Jodie MacDonald, Anaesthetic Specialty Trainee,
Dr Phil Bonnett, Anaesthetic Consultant, Sheffield Teaching Hospitals NHS Foundation Trust

Dr Arran Marriott
Anaesthetic Specialty Trainee, Sheffield Teaching Hospitals NHS Foundation Trust

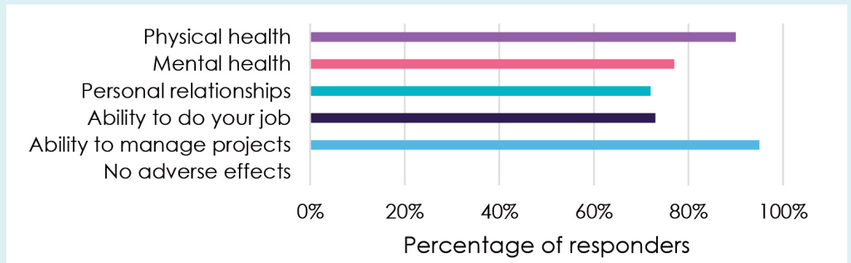
Fatigue is a state of reduced mental and physical performance resulting from insufficient sleep and circadian rhythm disruption. It increases human error, and has resulted in catastrophes such as the Challenger space shuttle explosion. Demanding workloads, shift working, and understaffing contribute to fatigue in healthcare. Following the tragic death of an anaesthetist in training after a night shift, a 'Fight Fatigue' campaign has been launched by the Association of Anaesthetists. As a part of this campaign, anaesthetic trainees in south Yorkshire have been invited to complete an annual survey to assess the extent and consequences of their fatigue. The aim is to assess the impact of interventions and identify new contributing factors.

An email with a link to an anonymised electronic survey was sent to all trainees in the South Yorkshire School of Anaesthesia. The survey asked questions to assess the extent of fatigue, associated consequences, and experience with rest facilities.

The survey was sent to 105 anaesthetic trainees, and there were 61 replies – a response rate of 58 per cent. Almost 100 per cent stated that they felt too tired to drive home following a night shift, and 25 per cent stated that they got adequate sleep between night shifts. Alarmingly, 38 per cent stated that they have had either a car accident, near-miss or personal injury following a night shift. Figure 1 shows the consequences of fatigue for trainees. Sixty-four per cent felt that their fatigue has impacted on patient safety. Comments included references to poor handover, drug errors and near-misses.

The results show a concerning level of fatigue with alarming consequences. Compared to the survey of the previous year, the extent of fatigue reported is worse. This is despite a number of interventions such as the inclusion of fatigue awareness induction training, encouragement of trainee SPA time, and ensuring all rest facilities meet the Fatigue Group minimum standard. Possible reasons for the reported increase in the extent of fatigue include a restructuring of the training programme which resulted in longer commutes, and rota gaps resulting from an absolute reduction in the number of trainees by 19 in the time between the two surveys. We recommend that, in addition to maintaining current interventions and developing a culture of fatigue awareness, an annual 'Trainee Day' be held that focuses on improving trainee wellbeing. The wellbeing of trainees must be paramount when designing rotas and planning placements. Health Education England and other stakeholders should look to the energy industry, who have developed fatigue risk management systems which provide guidance for shift design, work environment, and personal countermeasures to combat fatigue.

Figure 1 Reported consequences of fatigue



LETTERS TO THE EDITOR

If you would like to submit a letter to the editor please email **bulletin@rcoa.ac.uk**

Dr David Bogod

Dear Editor,

Growing resilience and emotional intelligence

RCoA *Bulletin*;**115**:22-23

I have been encouraged in recent months by the increased interest in and recognition of the effects of burnout, stress and fatigue alongside the importance of emotional intelligence and resilience training for medical professionals as described by Dr El-Ghazali.

Dr El-Ghazali raises some important points, including highlighting the concept of a 'culture of wellness' and how the lack of this can negate the effects of an individual's natural resilience.

Certainly, as a trainee I am grateful to be working in a specialty that recognises the importance of these concepts and has endeavoured to develop a culture of support and openness.

However, having recently read Dr Kate McCombe's excellent summary of the case of Dr Bawa-Garba[1] in a previous edition of the *Bulletin*, I was struck by the advice and attitudes regarding reflective practice issued by the RCoA in response to the Williams review. There is a strange dichotomy of attitudes presented when comparing these two articles – on the one hand a recognition of the high-pressure, high-stakes nature of our role, with a move to be open and supportive, and on the other an undercurrent of fear and self-defence, unwilling to identify areas of weakness or admit human error and mistakes for fear of retribution. This tension, felt palpably by those who work on the front line and arguably fostered by certain voices within the medical community, threatens workforce retention, recruitment, trainee and consultant mental health, team communication and ultimately patient safety if left unchecked.

As I progress through my training and career I will strive to develop a 'culture of wellness' to nurture emotional intelligence and resilience in those who need it most, however, I have concerns that the growing 'culture of fear' may overtake this if not identified and addressed.

Yours faithfully
Dr Richard Morrison
ST3 Anaesthetist, Northern Ireland

Reference

1 Dr Bawa-Garba: crime and punishment...?, RCoA *Bulletin*;114:12-13).

Dear Editor,

Anaesthetic Soapbox #2: If I see one more 16G Venflon in the back of a patient's hand...

RCoA *Bulletin*;**114**:44-45

I now count the life lessons brought to us by Dr Harrop-Griffiths from atop his soapbox as one of the highlights of reading the *Bulletin*. Reading his recent views on the now seemingly ubiquitous use of 16G cannulae in obstetric anaesthesia, I can be sympathetic to most of his opinions, however I feel he has overlooked some subtle cultural factors that defend and inform this practice.

The modern anaesthetist cannot be seen to impose their own beliefs and values onto our patients and therefore use of 22G and 20G cannulae in obstetric practice must be discouraged due to the gender-normative connotations of their coloured caps.

This, it would seem, leaves the 18G, 16G and 14G models available and, in most parts of the UK that is true. However, as a trainee in Northern Ireland we must tread carefully here. There are social and cultural factors at play that seem especially relevant at the time of writing (mid-July – approaching a...cultural...bank holiday). To place a green or orange cannula in any vein in certain circles could very well be seen as a definite political statement that would not be conducive to an effective doctor-patient relationship.

Therefore, the only logical, sensitive and appropriate option is the much maligned 16G cannula in a neutral grey. The 'Switzerland' of cannulae – placed in whichever vein seems appropriate.

Yours faithfully
Dr Richard Morrison
ST3 Anaesthetist, Northern Ireland

Dear Editor,

Workforce challenges

RCoA *Bulletin*; **115**:36-37

I applaud Professor Pandit's recent article in the *Bulletin* on workforce challenges. He clearly explains the problems we face.

However, everyone knows the answer to the question he first poses: how many anaesthetists does it take to change a light bulb? The answer is exactly two. One to make the coffee, and the other to bleep the Operating Department Practitioner.

Kind regards
Dr Bernard Norman

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Dr Peter Featherstone
RCoA Heritage Committee Member and
Consultant in Intensive Care Medicine and Anaesthetics,
Cambridge University Hospitals NHS Foundation Trust

AS WE WERE...
Unsinkable, but unthinkable

The International Fisheries Exhibition of 1883 was a triumph of the Victorian era. Held on a 21-acre site in South Kensington, London, it was attended by more than 2.5 million visitors, who marvelled at the 'large and well stocked aquaria', as well as displays of 'lifeboats, life-saving, and diving apparatus'.[1]

Among those charged with judging the various life-jackets, belts, buoys and rafts was Dr Henry Robert Silvester (1828–1908), who had recently been awarded the Fothergillian Medal of the Royal Humane Society in recognition of his eponymous method of artificial respiration.[2]

Reviewing the exhibits, Silvester noted that 'from the earliest ages attempts have been made to render the human body capable of floating on water, but these efforts have mainly been in the direction of attaching to the body, when immersed, various substances of less specific gravity – such, for instance as the inflated skins of animals, life belts etc. Atmospheric air…has been most frequently employed, but there has been some difficulty in finding a suitable envelope for containing it'.[3]

Observing that 'it is atmospheric air which is universally employed by nature to produce buoyancy',[3] Silvester subsequently embarked on a series of unorthodox experiments examining the utility of 'hypodermic inflation'[4] as a means of preventing drowning.

His first public demonstration took place at the International Fisheries Exhibition in June 1883, where 'he showed a small dog, weighing 10 lb, whose subcutaneous tissue he had inflated with air, and which was then able to sustain a weight of 18 lb in water, in addition to its own weight'.[4] Silvester postulated that this technique could be used to render animals 'sufficiently buoyant to be employed either singly or yoked together to convey persons from a wreck to the coast'.[3] However, since animals might not always be present in cases of shipwreck, and 'human lives may be saved by being enabled to traverse a few yards of deep water'[3], Silvester went on to investigate the possibility of replicating the procedure in man –

Henry Robert Silvester. Oil painting, 1895
Credit: Wellcome Collection. Reproduced under Creative Commons Attribution (CC BY 4.0)

'In August 1883, at King's College Hospital, by means of a blowpipe and elastic syringe, I inflated at the wrist the subcutaneous tissue of the whole body with the result that in a few minutes sufficient air passed underneath the skin to support a weight in water of between 40 and 50 lbs… Although one can imagine the existence of circumstances which would justify such a proceeding as the above…the practice of it would require a certain amount of surgical knowledge. Moreover it would be impractical except under favourable circumstances, and there are probably few persons capable of accomplishing it in their own bodies.'[3]

Silvester therefore sought 'a much easier and more ready means of rendering the body buoyant in water… which might be performed without assistance in a moment under the most adverse circumstances, and by the most ignorant, if once instructed in it, and without danger or pain, and suitable alike for the roughest sailor or the most delicate female'.[3]

His proposed procedure required the drowning victim to make a small puncture 'in the mucus membrane of the inside of the mouth' using the point of a penknife, or a sharp pointed splinter of wood, 'the object being to open a communication for the passage of air from the cavity of the mouth into the subcutaneous spaces of the neck'. They were next required 'to close the mouth and nose, and make a succession of forcible expiratory efforts, when the air contained in the cavity of the mouth will pass freely into the subcutaneous tissue of the neck. These expiratory efforts, inspiration being effected through the nostrils, should be continued until the skin is fully distended with air, which will pass readily to both sides of the neck and down the chest as far as the nipples; and this is all that is required to render the body buoyant in water'.[3]

Silvester noted that 'the neck may be kept in an inflated condition by closing the puncture by pressure on the outside of the cheek by the finger, or by keeping the mouth distended with air; and when required the air may be immediately discharged from the neck by allowing the puncture to remain open, or by suction'.[3] While he deemed the technique 'perfectly harmless… almost painless, quickly done, and almost immediately recovered from',[3] it appears that few shared his enthusiasm.

References

1 Advertisement: International Fisheries Exhibition. *The Times*, 4 June 1883.
2 Transactions of Branches. A new method of resuscitating still-born children, and of restoring persons apparently drowned or dead. *Br Med J* 1858;**1**:576-579.
3 Silvester HR. On life-saving from drowning by self-inflation. *Lancet* 1885;**125**:11.
4 Annotations. Hypodermic inflation. *Lancet* 1883;122:129.

For more information about the Heritage Committee please email archives@rcoa.ac.uk

NEW TO THE COLLEGE

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

College Tutors

Northern Ireland

Dr B McAfee (The Royal Hospitals) in succession to Dr A Naphade

Scotland

South East Scotland

Dr S Nimmo (Western General Hospital) in succession to Dr J Morton

West of Scotland

Dr P Dean (University Hospital Monklands) in succession to Dr C Guha

Dr K Bennett (University Hospital Wishaw) in succession to Dr C Slorach

Dr J Morrison (Glasgow Royal Infirmary) in succession to Dr G Gallagher

*Dr G Tong (Inverclyde Royal Hospital)

England

East Midlands

Dr M Chablani (Pilgrim Hospital, Boston) in succession to Dr R Jaganthan

Dr I Sisley (Royal Derby Hospital) in succession to Dr M Walters

Dr V Jaggernauth (Lincoln County Hospital) in succession to Dr M Kakkar

London

Barts and the London

Dr E Ogilvie (St Bartholomew's Hospital) in succession to Dr S Giannaris

Dr F Murray (Whipps Cross Hospital) succeeding acting Tutor Dr G Kandasamy

KSS

Dr D R Helm (Worthing Hospital) in succession to Dr S Nene

Northern

Dr E Kothmann (University Hospital of North Tees and Hartlepool) in succession to Dr O Shalaby

Severn

Dr T Eastaugh-Waring (Gloucestershire Hospitals NHSFT) in succession to Dr J Stedeford

Certificate of Completion of Training

To note recommendations made to the GMC for approval, that CCTs/ CESR (CP)s be awarded to those set out below, who have satisfactorily completed the full period of higher specialist training in Anaesthesia, or Anaesthesia with Intensive Care Medicine or Pre-Hospital Emergency Medicine where highlighted.

September 2018

Birmingham

Dr Paul Southall

East Midlands

Dr Ziad Al-Rifai Dual ICM

East of England

Dr Alasdair Jubb Joint ICM
Dr David Newby

Imperial

Dr Vineetha Sathyaseelan Ratnamma

North Central London

Dr Elizabeth Cervi

North West

Dr Anna Crosby Dual ICM

Oxford

Dr Jyoti Misra
Dr Matthew Rowland Joint ICM
Dr Tandip Mann

Peninsula

Dr Phillipa Squires

South East (London)

Dr Razvan Vargulescu

St. George's

Dr Craig Johnstone

Wales

Dr Sunil Dasari
Dr Sean Tobin
Dr Sara Churchill
Dr Thomas Bird

Wessex

Dr Laura Tarry
Dr Clare Khaghani
Dr Jack Davies
Dr Alexandra Skubala

West of Scotland

Dr Christopher Love

West Yorkshire

Dr Randa Ridgway

April and May 2019

Barts & The London

Dr Hoon Lau

Birmingham

Dr Benjamin Porter Dual ICM

East Midlands

Dr Gurmukh Sandhu Dual ICM
Dr Bhavisha Shah

East of England

Dr Paul Mallett Dual ICM
Dr Henry Nash Dual ICM
Dr Susanna Ritchie-McLean Dual ICM

Mersey

Dr Mark Dunham
Dr Fozia Hayat

North Central London

Dr Mohammed Haque
Dr Bhavin Shukla

North West

Dr Alistair Sawyerr

Northern Ireland

Dr Catherine Taylor

Oxford

Dr Ian Edmond Dual ICM

Peninsula

Dr Robert Goss Dual ICM
Dr Emily Howells Dual ICM
Dr Madhavi Keskar

Severn

Dr Jeannine Stone

South East

Dr Louise Gent

South East Scotland

Dr Barry Schyma

Wales

Dr Gemma Keightley
Dr Laura McClelland

Warwickshire

Elena Lynes
Dr Daniel Shuttleworth Dual ICM

Wessex

Dr Russell Goodall Dual ICM
Dr Robert Wiltshire

West of Scotland

Dr Christopher Farley
Dr Clare McNulty
Dr Daniel Silcock Dual ICM

APPOINTMENT OF MEMBERS, ASSOCIATE MEMBERS AND ASSOCIATE FELLOWS

Members

Dr Lauren Kate Walton
Dr Jyothirmayi Nimmagadda
Dr Christine Frances Wood
Dr Gillian Rennie

Associate Members

Dr Paulomi Dey
Dr Fahad Salim
Dr David Ben Ari
Dr Sondekoppam Naganath Bhagirath
Dr Roshana Prasad Mallawaarachchi
Dr Samuel James Bhattacharjee
Dr Georgios Papanastasiou
Dr Ahmed Mohamed Bakr Ahmed
Dr Omolola Ifeoluwa Afelumo
Dr Melvin Alex Abraham
Dr Jo-Anne Strul
Dr Ivelina Evtimova
Dr Manan Bajaj
Dr Jayathi Hasara Subasinghe
Dr Chamani Dilrukshi Abeywickrama
Dr Ahmed Mohamed Mahmoud Mohamed
Dr Saad Nazir Kidwai
Dr Abdul Alim Khan
Dr Keerthi P
Dr Lucas De Braganca Freixo
Dr James Ian Bland

Affiliate

Mrs Kathleen Rachael Dixon

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APPOINTMENT OF FELLOWS TO CONSULTANT AND SIMILAR POSTS

The College congratulates the following fellows on their consultant appointments:

- Dr Mohammed Akuji , East Lancashire Hospitals NHS Trust
- Dr Alexandra Murphy, Royal Victoria Hospital, Belfast
- Dr Christopher Smith, North Devon District Hospital
- Dr Jodie Smythe, Royal Berkshire NHS Foundation Trust

DEATHS

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

- Dr Andrew Iain, MacLennan Glossop
- Dr Elizabeth Green, Stonehaven

Please submit obituaries of no more than 500 words to: website@rcoa.ac.uk.
All obituaries will be published on the College website (www.rcoa.ac.uk/obituaries).

CONSULTATIONS

The following is a list of consultations which the College has responded to in the last two months. Those published on the College website via our Responses to Consultations area (bit.ly/RCoA-consultations) are marked with an asterisk.

Originator	Consultation
GMC	Medical licensing assessment (MLA) content map consultation
Department of Health and Socal Care	Restricting promotions of products high in fat, sugar and salt by location and by price
Department of Health and Socal Care	Further advertising restrictions for products high in fat, salt and sugar
NHS Confederation	Defining the role of integrated care systems in workforce development

Centre for Perioperative Care

DEPUTY DIRECTOR

Building on the success of its world-leading Perioperative Medicine Programme, the Royal College of Anaesthetists is establishing within the College a cross-specialty Centre for Perioperative Care (CPOC) dedicated to the promotion, advancement and development of perioperative care. CPOC will facilitate closer and more effective cross-organisational working, changing inpatient pathways and integrating services through a multi-disciplinary team approach.

CPOC is now inviting applications for the position of CPOC Deputy Director.

Deputy Director

We are looking for a skilled and effective clinical leader with experience of leading change and delivering service improvement in perioperative care. The role will involve ownership and delivery of CPOC work-streams and deputising for the CPOC Director as required. This is an exciting opportunity for a senior clinical leader to help shape the development of perioperative medicine in collaboration with cross-specialty stakeholders and partners across the health and social care landscape.

The post is supported by the cost of 1 period of professional activity (1 PA) per week, back-filled to the post-holder's employing trust.

Application details

The job description and person specification for this role is available at www.rcoa.ac.uk/job-vacancies. For more information or to arrange an informal discussion please contact Sharon Drake, RCoA Director of Clinical Quality & Research: sdrake@rcoa.ac.uk

Closing date: midnight on Sunday 20 October 2019

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FRCA EXAMINERSHIPS
2020–2021

The College invites applications for vacancies to the board of examiners in the Fellowship of the Royal College of Anaesthetists (FRCA), for academic year 2020–2021.

Examiners will be recruited to the Final and Primary examinations. The number of examiners recruited to each exam will reflect the number of retirements from the board of examiners.

Applicants shall be assessed against a comprehensive person specification, which, along with the job description and applications form for this role can be downloaded from the examination pages of the College website (bit.ly/RCoA-Examiner).

An outline of key essential requirements for the role of FRCA examiner, which must be met at the time of application or as defined, are set out below (applicants must read the person specification information and job description before applying).

Essential

1 Fellow by examination, a fellow ad eundem, or a fellow by election of the Royal College of Anaesthetists (the College).
2 In good standing with the College.
3 Holds full registration, without limitation, with the General Medical Council.
4 At least three years experience as a substantive consultant/SAS grade.
5 Shall currently be active in clinical practice in the NHS.
6 Has the expectation of completing no less than six years and no more than 12 years as an FRCA examiner.
7 Can demonstrate active involvement in the training and assessment of trainees.
8 Good written and verbal communication skills.
9 Ability to work as part of a team.
10 Documentary evidence of satisfactory completion of equal opportunities training in the last three years and willingness to undertake further exam specific equality and diversity training on an annual basis.
11 Able to commit to long-term and active involvement in examiner duties including the ability to devote 11 days or more per academic year to the role. This includes both the delivery and development of the examinations.
12 Within the past five years shall have visited a Primary or Final FRCA examination. This must have been achieved by the time the shortlisting process takes place (February 2020).

Desirable

1 Shall demonstrate a special interest(s) directly relevant to the balance of expertise required in the board of examiners.

Copies of the person specification information, job description and application form can be downloaded from the website (bit.ly/RCoA-Examiner) or by contacting Mr Graham Clissett (020 7092 1521 or gclissett@rcoa.ac.uk).

The closing date for receipt of completed application forms is Monday 7 October 2019.

Call for papers

Special issue on *Women in Anaesthesia*

Guest Editors: Christa Boer, Ramani Moonesinghe, Cynthia Wong

As part of our ongoing commitment to initiatives that promote openness and diversity within the discipline of anaesthesiology, the *British Journal of Anaesthesia* has commissioned a special issue on ***Women in Anaesthesia*** to highlight the science and practice of anaesthesia as it relates to sex and gender, challenges facing women in anaesthesia today and the role women have played in the development of the discipline.

Original submissions are invited from broad areas of focus relevant to anaesthesiology. Examples include:

- Preclinical and clinical differences in the pharmacology of anaesthetic drugs between men and women
- Clinical concerns specific to the anaesthesia care of women, influence of sex and gender on anaesthesia outcomes
- Role of gender in anaesthesia care team performance and outcome
- Role of gender in academic anaesthesiology, including research, publication, and leadership
- Role of women in the history of anaesthesiology
- Clinical investigations, laboratory investigations, systematic reviews, meta-analysis, narrative reviews and position papers are welcome for consideration

BJA WOMEN IN ANAESTHESIA

RESEARCH • DISCOVERY • EDUCATION

The timeline for this Special Issue is as follows:

Submission Deadline: **31st October 2019**

Acceptance Deadline: **18th December 2019**

All papers will be subject to rigorous peer review for publication in early 2020 to coincide with International Women's Day (March 8, 2020) and Women's History Month. For detailed guidance on submission please view our Instructions to Authors page at https://bjanaesthesia.org

Please submit papers online at https://mc.manuscriptcentral.com/bja

Patient Safety Conference 2019 (Paediatrics) - SALG

SAFE ANAESTHESIA LIAISON GROUP

Thursday 31 October 2019

Location: Royal College of Anaesthetists, London
Organisers: SALG and APAGBI

Book now: www.anaesthetists.org/salg2019

Association of Anaesthetists | APAGBI | RCoA

SAFE ANAESTHESIA LIAISON GROUP

SALG-BIDMC Fellowship

In collaboration with the Association of Anaesthetists and the Royal College of Anaesthetists, the Safe Anaesthesia Liaison Group (SALG) are pleased to announce that the second round of the SALG-BIDMC Scholarship is now open, offering a unique 27 month programme of clinical work and formal training through Harvard Medical School (start date July 2020), leading to a Masters in Quality & Safety designed to develop international expertise in peri-operative medicine. The Scholarship is open to trainees, SAS or consultant grade anaesthetists. Please note at least Steps 1 and 2 of USMLE are essential.

The closing date for applications will be **Friday 10 January 2020**, with interviews at the end of January 2020.

For more information, please visit bit.ly/SALG-BIDMC or email Professor Jaideep Pandit (jaideep.pandit@dpag.ox.ac.uk).

RCoA Royal College of Anaesthetists

The College Shop

Led by our commitment to environmental responsibility, we are pleased to annouce that our College Shop has added items such as an eco-friendly RCoA branded travel cup and water bottle.

As well as being useful and attractive items, these are a great way to show your involvement with, and commitment to the College and the specialty.

Visit our website at bit.ly/College-Shop for more information.

bit.ly/College-Shop
membership@rcoa.ac.uk

MSA

Mersey School of Anaesthesia

"If you feed the children with a spoon, they will have learn to use the chopsticks"

FINAL FRCA WRITTEN CRQ E-CLUB

With the Introduction of CRQs into the Final FRCA Written Examination we appreciate that opportunities to Exercise & Practice New Question Formats and Techniques are limited

Therefore;
Following a Taster Round which is currently underway,
The MSA is offering Final Trainees Membership to our new CRQ E-Club

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

Benefits Include;
Single Membership Fee; Members are entitled to all benefits until successful in the Final Written Exam
Timed & Disciplined Practice
Acquisition of useful Answer Guidances from Other Members
Valuable Motivation towards Sustained Revision

Apply early to gain full benefit from the Club

The Next Round will be due to start in October 2019 in preparation for the March 2020 Examination

Please register your interest by emailing: e-club@msoa.org.uk

Courses for the Royal College of Anaesthetists Examinations			
Courses	**Dates 2019/20**		**Capacity**
Primary SBA/MCQ	**11 – 17 October**	**31 January – 6 February**	**100**
Primary OSCE Weekend	**4 – 6 October**	**10 – 12 January**	**48**
Primary Viva Weekend	**18 – 20 October**	**3 – 5 January**	**72**
Primary OSCE/Orals	**25 October – 1 November**	**17 – 24 January**	**48**
Final Written 'Booker'	**11 – 15 August**	**9 – 13 February**	**90**
Final SBA/MCQ	**16 – 22 August**	**14 – 20 February**	**100**
Final SAQ Weekend	**23 – 25 August**	**TBC**	**100**
Final Viva Revision	**19 – 24 October**	**May 2020**	**100**
Final Viva Weekend	**22 – 24 November**	**June 2020**	**100**

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

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

The advice to Trainees is that they should only attend MSA Courses when they consider themselves adequately Prepared for the Imminent Examinations.

To see Details of all of our Courses please visit: www.msoa.org.uk
'Like' Mersey School of Anaesthesia on Facebook for News and Updates

LEADERSHIP AND MANAGEMENT

These interactive workshops offer a balance of plenary sessions, group work and exercises with emphasis on real life issues, open and one-to-one discussions to help you become an better leader in your management role.

The Essentials
23–24 September 2019 | Bristol
5–6 May 2020 | RCoA, London

Specifically designed for anaesthetists this course will help you develop your leadership skills and uncover your behavioural preferences, exploring how it impacts your working relationships.

Leading and Managing Change
7 October 2019 | RCoA, London

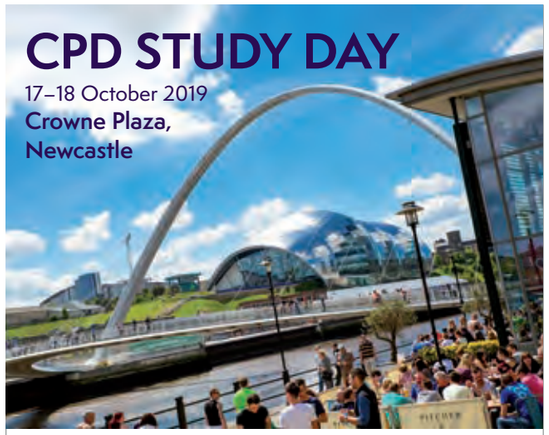
This course will equip you with knowledge and skills you need in order to effect change successfully in your organisation.

Working Well in Teams and Making an Impact
20 November 2019 | RCoA, London

Enhance your understanding of how teams work through the introduction of tools and frameworks that can be applied to your own team.

Personal Effectiveness
19 March 2020 | RCoA, London

Gain insight into your own and others' behavioural preferences and discover how this can impact on your working relationship and role.



CPD STUDY DAY

17–18 October 2019
Crowne Plaza, Newcastle

Topics include:

- Getting It Right First Time (GIRFT) in perioperative medicine and ICU
- End of life care in ICU
- Prehospital medicine
- National Emergency Laparotomy Audit (NELA) from a surgeon's and geriatricians perspectives

AIRWAY COURSES

Advanced Airway Workshop
24 September 2019 | RCoA, London

UK Training in Emergency Airway Management (TEAM)
28–29 October 2019 | RCoA, London
7–8 November 2019 | Royal Infirmary of Edinburgh

Tracheostomy Masterclass
10 January 2020 | RCoA, London

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

ANAESTHETISTS AS EDUCATORS

Our series of Anaesthetists as Educators events support clinical educators in delivering high quality training and education in the workplace. Participation in the courses provides supporting evidence towards the GMC approval process for trainers.

An Introduction
1 October 2019 | RCoA, London

Provides an overview of postgraduate medical education in anaesthesia. This highly interactive course is suitable for doctors with no previous training in teaching or medical education.

Simulation Unplugged
2 October 2019 | RCoA, London

For those developing their knowledge and skills in delivering educational simulation. This course is designed to debunk the myths and get back to the nuts and bolts of what you and your learners need.

Teaching and Training in the Workplace
14–15 November 2019 | RCoA, London

Intended for doctors with some experience of teaching and supervising trainees, this course looks at the education and assessment of trainee anaesthetists and raises awareness of some of the key concepts associated with education.

Anaesthetists' Non-Technical Skills (ANTS)
22 November 2019 | RCoA, London
28 April 2020 | RCoA, London

For those wishing to increase their understanding of how behavioural aspects of performance contribute to patient safety. Learn about the concepts and vocabulary used to formulate a personal strategy using the ANTS framework.

PROGRAMME AVAILABLE ONLINE

Updates in Anaesthesia Critical Care and Pain Management

24–26 September 2019 | RCoA, London
4–6 November 2019 | The Studio, Birmingham
25–27 February 2020 | RCoA, London

WINTER SYMPOSIUM 2019

Patient safety, health and wellbeing

10–11 December 2019
RCoA, London

The 2019 Winter Symposium will feature a varied programme combining lectures and short updates.

www.rcoa.ac.uk/winter symposium-2019

Discounts may be available for RCoA-registered Senior Fellows and Members, Anaesthetists in Training, Foundation Year Doctors and Medical Students. See our website for details.

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ANAESTHESIA 2020

18–20 May 2020
Old Trafford, the Home of Manchester United
www.rcoa.ac.uk/anaesthesia

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Fitter Better Sooner

Endorsed by

Royal College of General Practitioners
Royal College of Surgeons

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

The Fitter Better Sooner toolkit consists of:

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

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

We have also created printable posters, flyers and stickers to help you signpost patients to the toolkit. The animation can be shown on TVs in waiting areas. You can find all these additional resources and instructions on how to download the animation in MP4 format on our website here: bit.ly/RCoA-FBSresources

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

It has been shown that people who improve their lifestyle in the run up to surgery are much more likely to keep up these changes after surgery.

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