

AESTHESIA

DEPARTMENT OF ANAESTHESIA

Issue 02: December 2015

St. George's University Hospitals NHS
Foundation Trust



ACSA-We Did It!

[/Reflections](#)

[/Articles](#)

[/News](#)

The most admired anaesthetist



AESTHESIA

MEANING:

The normal ability to experience sensation

ETYMOLOGY:

Back formation from anaesthesia (loss of sensation), from Greek an- (not) + aisthesis (sensation). Earliest documented use: 1829; anaesthesia is from 1721.

Cover photo

The Sir Joseph Hotung Centre

Housed in a striking pyramid-shaped building to the right of the hospital's main entrance, this was set up through a collaboration between St. George's Hospital and St. George's, University of London. It was funded through a charitable appeal and by a benefactor, Sir Joseph Hotung.

The Centre provides a facility for research into muscular-skeletal disorders, special interest clinics, education and national and international meetings.

The distinctive pyramid shape of the Hotung building is intended to provide a focal point and an easily identifiable destination within the large complex of hospital buildings that make up the St. George's site.

AESTHESIA

Number 2 • DECEMBER 2015

Editor : Tony Addei

Editorial Board:

Nawaf Al-Subaie

Sohail Bampoe (Trainee Representative)

Himala De Zoysa

Mark Edsell

Sarah Hammond

Bernard Liban

Puneet Ranote

Helena Smith

Dominic Spray

Robin Sunderland

Copyright © 2015 tadproductions.

TABLE OF CONTENTS

INSIGHTS

4

Guest Editorial
Dr Carolyn Johnston

5

ACSA accredited
departments in UK

6

Spotlight
We Did It!

7

From the past
• *Sir Frederic Hewitt*
• *The story behind
the patient gown*

ARTICLES

8

Improvement Science -
Fact or Fiction
Dr Sioned Phillips

10

War to Ebola: 20 years of
MSF
Dr Greg McAnulty

12

Anaesthetic Dilemma
Dr Sam Bampoe

14

Our health - who is re-
sponsible
Dr Myra Malik

NEWS

15

Department news in pictures

- *Training - Emergency Un-
docking of da Vinci robot*
- *Christmas Party*
- *Caption competition*
- *The most admired anaesthetist*
- *Retirements*

NAP6

Perioperative Anaphylaxis



- The Royal College of Anaesthetists' 6th National Audit Project
- Starting 5th November 2015
- Watch out for e-mail regarding web-based survey
- **100% response rate mandatory!**
- **Instructions to follow**

Surginet-Anaesthesia Project Looking ahead

October 2015 – January 2016:

Testing

January 2016:

Cerner Presentation to department

January 2016 → *End user training*

February 2016: **Go Live**

Guest Editorial



Dr Carolyn Johnston
Consultant Anaesthetist

I am very pleased to write this editorial on Quality Improvement for AESTHESIA. There is a lot of fantastic improvement work in the department; on safety, patient experience and clinical outcomes.

We have introduced simple formal processes to improve safety during the handover period for our emergency 'CEPOD', recovery, maternity and theatre teams. Measuring trainees' satisfaction has led to changes to the working day for emergency bleep holders. This has resulted in increased and improved exposure to good training opportunities.

We actively encourage a strong governance and safety culture. Several colleagues are improvement enthusiasts and lead many trust-wide quality initiatives. They also represent the hospital and specialty on a number of national schemes and representative bodies. Anaesthetists are improving outcomes by leading and engaging in the many enhanced recovery programmes in the trust, trialing innovations in specialties such as cardiac and airway, and of course, delivering the acute pain service. Patient experience has been improved by tackling lengthy pre-operative fasting times and improving patient information. We are working on staff experience with small improvements to the department environment. These are only a few examples of the huge amount of improvement work that is going on.

A lot of work went into our Anaesthesia Clinical Services Accreditation (ACSA) assessment: developing and measuring assurance for a robust set of standards. One of the college's aims with ACSA is to use it as a vehicle for quality improvement.

There is a longstanding criticism that inspection

does not drive improvement: put another way: "weighing a pig does not make it fatter". To make sure we do not let our efforts towards ACSA accreditation go to waste, it is important that we do not let that work sit on the shelf gathering dust, as an unread folder of policies and guidelines. We now need to see how these new policies and processes work in practice. The bulk of improvement happens in the time after a change is introduced. Implementing something new should be more than laminating a poster and sending out an email. We can now evaluate our new processes in the working environment, modify and develop them over time.

This interesting cycling analogy by Don Berwick- "You win the Tour de France not by planning for years for the perfect first bicycle ride, but by constantly making small improvements."- is apt. Quality improvement may be regarded as both a science and a team sport. An aggregation of many small gains adds up to a big improvement, as the British cycling team showed us a few years ago.

For me, the ACSA process has felt like a group activity, with a lot of us working on a lot of standards that were interlinked. The inspection days felt rather surprisingly, like a brilliant opportunity to show that all off. The inspectors were quite impressed at the breadth and depth of work going on throughout the department, and rightly so.

We cover a vast array of specialty areas and deal with testing acuity and workload. We have a strong record of sharing, learning and discussing

safety incidents openly. It is only a small step to adopt the same approach for all our improvement work.

Let me share this article, [Build a change platform, not a change program](#) by Gary Hemel, who is a Professor at the London Business school. He writes about how we should move from working on individual change projects, to building a change platform. Currently, improvement efforts are an 'episodic disruption of the status quo'. We try to improve things by taking on a project as an individual or small team, designing something new, and then launching it on our colleagues. The problem with this approach is that it quite often fails. Instead of rolling out projects designed in isolation, we should invite everyone to take part and have improvements initiated by all of us and discussed between all of us, who are encouraged

to do so by supportive colleagues and management. It is an opportunity for group activity.

The most successful improvements happen in places where staff are fully involved, open to honest discussions and develop improvements democratically and organically, rather than a rigid, engineered process that is rolled out from above. It would not require many changes to use this kind of approach—just a few more improvement enthusiasts and an effective means of canvassing opinions and communicating changes. The results would include many more successful improvement efforts and an engaged and happy workforce.

In five years' time, when the ACSA inspectors return, Dr. Williams can smile serenely, because improvement would really be business as usual.

“You win the Tour de France not by planning for years for the perfect first bicycle ride, but by constantly making small improvements.”

– Don Berwick

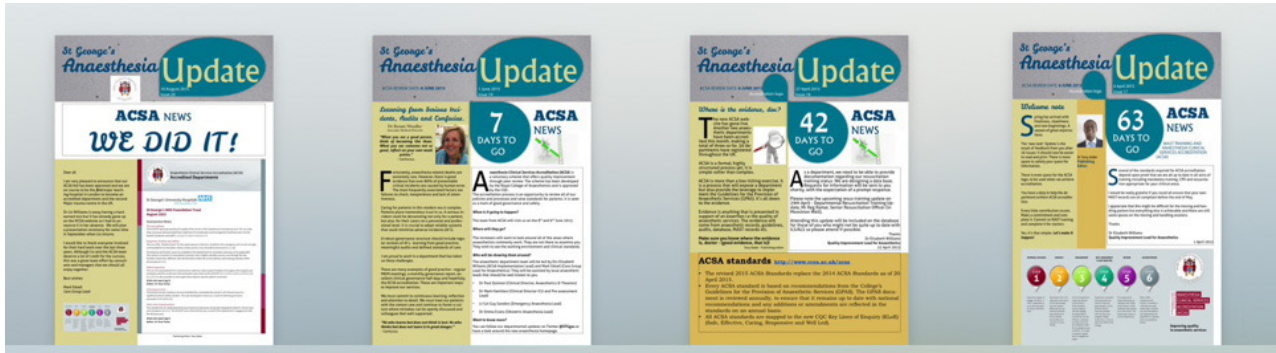
ACSA accredited departments

Only five anaesthetic departments are accredited in the *entire UK* (October 2015)

Midlands and East of England	North of England	South of England	Wales, Northern Ireland and Scotland	London and Thames Regions
West Suffolk Hospital	Harrogate and District Hospital	Plymouth Hospitals NHS Trust		Homerton University Hospital St George's NHS Foundation Trust 

Spotlight

ACSA - We Did It!



We are the first major teaching hospital in London and the second major trauma centre in the UK to become an accredited department.

“The strength of the college is the relationship with the NHS and it was great to see that working so well...”

I wish you every success in the future and congratulations again on gaining ACSA accreditation.”

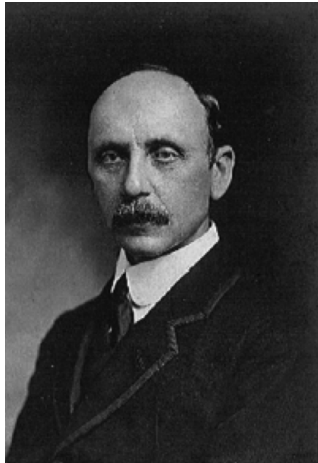
Tom Grinyer
Chief Executive Officer
RCoA



Dr Mark Edsell, clinical lead for anaesthesia and Dr Liz Williams, lead for ACSA at St. George's Hospital, receive the commemorative ACSA plaque from Dr J-P van Besouw, past President of the RCoA.



From the past



Sir Frederic W. Hewitt
(1857–1916)

The first anaesthetist to be knighted.

Sir Frederic William Hewitt commenced his studies in medicine in 1880 at *St. George's Hospital Medical School*. He was an outstanding student and received both the Brackenbury Prize in Medicine and the Treasurer's Prize.

His reputation as an anaesthetist resulted in his appointment as Anaesthetist to the King in 1901. In 1902, he became Physician-Anaesthetist at *St. George's Hospital*. In the same year, Hewitt gave King Edward VII an anaesthetic for the drainage of an appendix abscess two days before his scheduled coronation (the coronation was delayed for six weeks). The surgeon was Sir Frederick Treves.

Hewitt was knighted in 1911.



UNVEILED: THE PATIENT GOWN

May/June
2006



SUITS YOU: The new gown is 'comfortable, practical and dignified', say patients and nurses

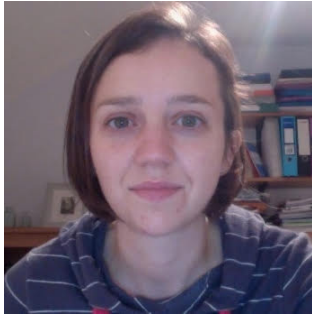
A HOSPITAL gown that actually protects patients' modesty? Hard to believe but, yes, from now on the Trust's patients will be spared the embarrassment of accidentally baring their bodies to others as a new gown – designed by nurses and described as 'practical, comfortable and dignified' – hits the wards.

The new garment, dubbed a 'dignity' gown, is similar in style to a Japanese kimono. It is wider and longer than its predecessor and fastens together at the front rather than at the back.

The design of the gown allows doctors and nurses easy access to a patient's arm or neck to place intravenous drips without the need to ever remove the garment.

Jayne Quigley continues: "The fabric of the new gown looks and feels so much better and is practical, comfortable and dignified.

"The cornflower blue colour suits all skin tones and makes everyone look better. We've provided access at the neck for patients who need drips and drains, and sleeves have been given poppers so that they can be opened for patients with large arms."



Dr Sioned Phillips
Specialty Trainee

Improvement science fact or fiction?

Quality improvement (QI), has become one of the new buzzwords, but what does it mean and whom does it apply to?

What is it?

Quality improvement describes the process of identifying a problem, implementing change for the better and sustaining that change. 'Quality' has many meanings within healthcare but should not be thought of as just equating to safety. It also encompasses effective, timely, equitable patient centred and efficient care. One definition of quality improvement is 'a better patient experience and outcomes achieved through changing provider behaviours and the organisation via systematic change method strategies'.

The focus of any definition of quality improvement is how the method of change is achieved. The NHS change model describes the key areas that must be considered when implementing a QI project. These are: leadership for change, spread of innovation, improvement methodology, rigorous delivery, transparent measurement, system drivers and engagement to mobilize.

PLAN (pan-London perioperative audit and research network) is a regional trainee led group dedicated to advancing audit, research and quality improvement projects.

Who does it apply to?

All trainees from intermediate level will need to show an understanding and involvement in QI. In annex G of the Royal Colleges CCT curriculum 2010, there is a whole section dedicated to improvement science, safe and reliable systems. It explains how, from intermediate training, a deeper understanding of change management is needed. It covers the multiple acronyms and phrases that should be understood on the journey to implement and sustain change in the work environment.

A good accompaniment to this is a document edited by Professor Carol Peden titled 'Quality improvement in Anaesthesia'. This has several short chapters that look at the history of quality improvement, tools to implement and monitor change, and examples of trainee led projects. It makes for an interesting read and describes the plan-do-study-act (PDSA) cycle, driver diagrams, run charts, the performance polygon and others.

We have all done an audit but now we need to move on and think about where we are, what needs to change and how can we do that. Once we have implemented change, the real hard work begins with sustaining it.

How to get involved/ learn more.

There is an intermediate trainee study day dedi-

cated to improvement science run by Dr Carolyn Johnston. Dr Liz Williams is the department lead for quality improvement.

PLAN (pan-London perioperative audit and research network) is a regional trainee led group dedicated to advancing audit, research and QI projects. As a first project, QUINCE (QUality of INtraoperative CErebral protection) outstripped all expectations and helped establish the PLAN network. Data from 25 centres in London including seven hospitals from the St. George's rotation contributed to an abstract that won 2nd prize in the audit category at the AAGBI Winter Scientific Meeting in January 2015. The second project PAINT (PAin in INTensive care) was more ambitious and involved collaborating with a neighbouring anaesthetic trainee network, SEARCH KSS. This further tested the model used to run QUINCE, having regional leads to coordinate hospitals within specific geographical regions. It worked well and involved 44 centres, representing over 700 patients.

St George's trainee participation for PLAN over the period were Peter Odor, Sohail Bampoe, Sioned Phillips, Hannah Williams, Chiara Tosini, Alessandra Parini, Ximena Watson and Maria Cheresheva. PLAN is looking for audit and quality improvement projects designed by trainees that promote excellence in patient care. This is a great opportunity to network, get involved in large-scale projects and research, with the aim to present or publish your work. The PLAN website can be accessed via: www.uk-plan.net/home

A useful project undertaken at St George's hospital involved the handover process during a given patient's journey through theatre. This area had been flagged up for a couple of reasons. One of the priority 1 standards of ACSA, is that there are documented and agreed policies for the handover of patient care at any point along the perioperative pathway. There have also been several serious incidents (SI's) relating to adverse events that have occurred in patient care as a consequence of incomplete/ inadequate handover. This simple project looked at why problems occur and used several PDSA cycles to produce a cognitive aid to improve handovers and patient care.

Quality improvement science has some great tools to produce real differences and sustain change. It should be incorporated into every anaesthetist's portfolio.

References

1. The Health Foundation (2013). Quality improvement made simple, what everyone should know about health care quality improvement.
2. Øvretveit J (2009). Does improving quality save money? A review of evidence of which improvements to quality reduce costs to health service providers. London: The Health Foundation.
3. NHS IQ. The NHS change model.
4. The Royal College of Anaesthetists (2010). CCT in Anaesthesia, Annex G, teaching and training, academic research, quality improvement and management for anaesthesia.
5. Peden C (2012). Quality improvement in Anaesthesia. Raising the Standard: a compendium of audit recipes. Royal College of Anaesthetists.

ANAESTHESIA TOP 5

Topics for November

1. The Cerner Electronic Anaesthesia Record is coming.
2. The department has a number of leadership and clinical roles for consultants old and new.
3. Hand Hygiene.
4. New contract negotiations for doctors in training.
5. Theatre and Anaesthesia service line review.

Mark Edsell
Care Group Lead

See e-mail
Follow: @StGas

“Sometimes doing your best is not good enough. Sometimes you must do what is required.”

Winston Churchill



Dr Greg McAnulty
Consultant Anaesthetist

War to Ebola:

20 years of MSF

Almost exactly 20 years ago, I was trying to leave Gorazde, one of the besieged enclaves in eastern Bosnia, so I could get back to work in London.

I was working as an anaesthetist for Médecins Sans Frontières (MSF) and had promised that I would go back to my senior registrar post in July. Unfortunately, the final “Spring Offensive” of the Bosnian war had been underway since the snows had melted in April and a ceasefire had to be negotiated for us to change teams. The surrounding forces had mined the road. It was a strange time.

The town was being shelled and shot at every day and there were episodic battles in the surrounding area. In the end, Rico, the only other expatriate member of our little team (then a logistician from Normandy and still a friend), and I were able to leave. We were able to greet our replacements briefly as we exchanged vehicles in the no man’s land between the enclave and the Serb republic, before setting off back to Belgrade.

It seems a very far away time. We communicated with the outside world by HF radio, smuggled in letters and, occasionally, sent satellite telexes. There was no television and the little electricity there was came mostly from home-made hydro generators. The neighbouring enclave was Srebrenica and during the weeks afterwards, we now know that more than 8,000 people, mostly men and boys, were killed in the worst genocide in Europe since the second world war. We did not realise that when we thought things were bad for us, they were so much worse for others. MSF

had been providing medical staff, materials and drugs to the hospitals in the eastern enclaves of Gorazde and Srebrenica for the previous year or so.

I went back to Gorazde the following year after the peace agreement had been signed to help close down the project. Although there was no siege at the time, I remember having to negotiate again about getting away. But this time, it was to find out if it was possible to stay longer. Communications technology had advanced a bit. We had a phone in a suitcase which, I had to point at a satellite using a compass and a set of tables. I think I was the first in our team to use it as it was very expensive to make a call. Remarkably, it worked and I was able to speak to Mike Hulse (then chairman of the St George’s anaesthetic department) who said, “No trouble. I have someone who I can slot into your rotation. We will see you when you get back.” There was less bureaucracy in those days!



Gorazde Hospital, Eastern Bosnia: May 1995 (operating theatre on right, mortuary on left).



Ambulance reception, Kailahun Ebola Treatment Centre, Eastern Sierra Leone: December 2014.

I also became interested in the organisation behind international medical humanitarian work. At the time, MSF UK was a fairly small outfit. I stood for election to the board of governors and subsequently became the chairman (or “president” in MSF speak). I suppose things were simpler then, and I was able to fit the work into evenings and weekends. Travel was mostly to spend days in dull rooms in various parts of Europe but occasionally to more interesting places in Central Asia and East and West Africa. Most of all, it was a fantastic privilege to meet so many people who work with MSF around the world. I was chairman for five years and on the International Council Board for four years.

Heidi, myself and our then two year old son went to Alice Springs for a year in 2007. Heidi had originally found jobs for us in Rwanda but it fell through. I had spent a few months after the end of medical school in the Northern Territory and stayed in a couple of indigenous communities, so in some ways, it was like going back to somewhere familiar. We worked in a district general hospital (DGH) which had most of the facilities we have in UK hospitals, but in remarkable isolation. Our catchment area was the size of western Europe. Most of our patients were tribal aboriginal people who suffered the consequences of the clash of two cultures.

When we came back, my involvement with MSF was limited to talking to returned UK MSFers. A few of us run a volunteer service which aims to give those coming back a chance to talk about their experiences. Apart from MSF, I have spent a few, very short stints giving anaesthetics or teaching with a couple of other organisations: ReSurg Africa in Sierra Leone and the Royal Australian College of

Surgeons in East Timor.

When the Ebola outbreak hit West Africa, like many, both Heidi and I felt we should see if we could do something to help. Heidi had been to Sierra Leone a couple of times before as well (once to examine a group of graduating anaesthetic nurses sponsored by the WFSA) and we drew straws. I won and my colleagues in anaesthesia and critical care were generous enough to cover my absence for the eight weeks I was away and in pseudo-quarantine.

In the years since my last proper mission with MSF, the organisation has become much more professional and organised. It was always pretty good at getting you where you needed to be (not always so good at remembering to get you back again) but now the communication, training, transport and accommodation were extraordinarily slick. The work was grim but the national staff (who bore the brunt of coping with the consequences of Ebola on their communities, their families and who, sometimes, caught the disease and died) were inspiring. They are still there, of course, and in Guinea, Sierra Leone and again now Liberia, so is Ebola.

In the twenty years or so that I have been involved with thinking about, and occasionally, being hands-on in several international humanitarian medical aid activities, the business has become much more professional. Standards of intervention, evaluation and reporting, as well as institutional governance have become more defined. Organisations like MSF have grown both in size and bureaucracy.

What happened because of a personal idea of what was right is now defined a lot more by policy. I have to confess that recently in Sierra Leone, I and my fellow “MSF dinosaurs” occasionally complained that, “it wasn’t like this in my day”. But in many ways that is a good thing. There is much less “us and them” in the relations between expatriate and national staff. The standards of care are also closer to those we would expect in the developed world.

All this work with MSF has been possible because of the great generosity of thousands of donors. I have also relied on the generosity of colleagues who have made it possible for me (and others) to get away.

If you are interested in reading more about my recent time in Sierra Leone you could go to:

<https://greginsl.wordpress.com>



Dr Sohail Bampoe
Specialty Trainee

“Anaesthetic Dilemma”

The Evolving Role of Anaesthetists in the Perioperative Care of Surgical Patients

In the UK, anaesthesia has historically only been administered by qualified doctors. In recent years, a new non-medical role has been introduced successfully in many centres.

Physicians' Assistants (Anaesthesia) (PA(A)s) are part of the clinical team in several departments of anaesthesia. They were introduced into the UK in 2004, as a response to the predicted workforce shortages expected following the implementation of the NHS Plan, and the European Working Time Directive. Following an extensive review, the Department of Health and the Royal College of Anaesthetists (RCoA) concluded that, overseas models of care based on collaboration between medical and non-medical anaesthesia providers were safe, and could potentially provide a solution for workforce planning issues (RCoA, 2002).

The opinion among doctors has been divided since the introduction of PA(A)s. There are many anaesthetists who advocate their role and value their positive contribution to the anaesthetic team. However, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) also acknowledges that many anaesthetists have perceived the role of these practitioners as a threat to future job opportunities and training in anaesthesia. This has generated a feeling animosity and scepticism from some individuals. Whilst these negative opinions are mostly borne out of cynicism, these highly trained technicians may actually pose a credible threat to the role of the anaesthetist as it currently exists. Over the

last decade, the predicted shortage of medically trained anaesthetists did not become a reality.

There are a number of obvious reasons why PA(A)s remain an attractive prospect for NHS trusts. Currently, anaesthetists are the most populous specialty in hospital medicine, with many large trusts employing close to, or even more than a hundred consultant anaesthetists, at a considerable cost. This reflects a shift in recent years towards consultant delivered services in the UK. However, analysis of foreign systems of care which rely on a 2:1 ratio of consultant to non-medical anaesthesia providers, such as the system currently employed in the United States, reveals that safe, high quality care is in fact the norm.

In 2011, the AAGBI concluded that since the introduction of PA(A)s into UK practice in 2004,

The future of safe surgery lies in the development of cohesive, multidisciplinary, perioperative medical teams, with anaesthetists best placed and best equipped to lead them.

there has been very little, or no evidence of adverse patient outcomes. They found that patient pre-assessment was better facilitated, and that theatre utilisation was improved. Many trainee anaesthetists reported that the introduction of PA(A)s meant that consultants had more time in theatre for direct teaching and training. Taking these facts into account, the role of PA(A)s looks a lot more enticing to employers who are striving to provide safe and cost effective services in times of austerity.

This is a bitter pill to swallow for some anaesthetists who remain, opposed to sharing their intra-operative responsibilities to patients. However, the response from anaesthetists should not be to oppose the introduction of these well trained technicians into the operating theatre environment, but instead, to seize the opportunity to expand their own duties of patient care and apply themselves beyond the operating theatre walls.

The RCoA has recently launched its perioperative medicine vision document, which envisages the evolution of anaesthetists from intra-operative technicians into perioperative physicians. This is both a timely and necessary change in direction for anaesthesia as a specialty. The global volume of surgery is increasing, and our population also continues to age. The result is an epidemic of avoidable surgical mortality and morbidity in a population who are presenting for surgery with more co-morbid disease, and greater perioperative needs than ever before.

Anaesthetists are highly skilled physicians who should apply their medical skills through the entirety of a patient's surgical journey. This way, they can better meet complex needs, rather than limit themselves only to the provision of intra-operative care. The future of safe surgery lies in

the development of cohesive, multidisciplinary, perioperative medical teams, with anaesthetists best placed and best equipped to lead them.

Few specialties, if any, are more notable than anaesthesia for their history of improving patient safety, especially through the early and enthusiastic adoption of innovative and pioneering practices. The introduction of PA(A)s should perhaps, be considered to be a similarly progressive advance in anaesthetic practice, which will both catalyse and facilitate the evolution of anaesthetists into perioperative physicians.

Embracing PA(A)s into anaesthetic practice will allow anaesthetists to enjoy some flexibility, whilst delivering the same outstanding quality of intra-operative care. The flexibility to address the pressing need to improve the care that is provided throughout the entire perioperative period, with the ultimate goal of working closely together as a team, to improve patient outcomes.

References:

1. Pearse, R.M. et al. (2012). Mortality after surgery in Europe: a 7 day cohort study. *Lancet*, 380(9847). 1059–65.
2. The Association of Anaesthetists of Great Britain and Ireland (2011). Physicians' assistants (anaesthesia) Review. 1-15.
3. The Royal College of Anaesthetists (2015). Perioperative medicine - the pathway to better surgical care. 1-23.
4. The Royal College of Anaesthetists (2002). The role of non-medical staff in the delivery of anaesthesia services. 1–24.
5. Weiser, T.G. et al. (2008). An estimation of the global volume of surgery: a modelling strategy based on available data. *Lancet*, 372(9633) 139–44.

People who say it cannot be done should not interrupt those who are doing it.

George Bernard Shaw



Our Health

-who is responsible ?

Dr Myra Malik
Clinical Fellow

In June last year, the Royal Society of Medicine (RSM) held a meeting on Our health – who is responsible?

This was a joint event organised by the pharmaceutical medicine & research, and the open sections of the RSM. The meeting looked at the differing views on improving the provision of healthcare.

The meeting was very topical because in the same week, the national health service (NHS) had been declared the world’s best healthcare system by an international panel of experts. They rated its care superior to countries which spend far more on health. So, we must be doing something right. But as always, we could do better. Bearing in mind the changing needs of the population, how could we meet these challenges in the future?

There was a packed and varied schedule of eminent world class speakers, which makes it quite a challenge to pick the highlights. As a clinician, gaining insight from a patient’s perspective is always a privilege and a humbling experience.

Mr Micheal Seres gave an interesting and truly inspirational account of his journey as a patient with chronic bowel disease. He is also a recipient of an intestinal transplant. He is the patient lead for #NHSSM, a facilitator for the Centre for Patient Leadership and a digital strategy advisor to the Patients’ Association & Oxford Transplantation Foundation. He has harnessed social media (twitter and his blog), as a way of communicating with other patients

and his clinicians. He highlighted the need for real patient representation in improving the delivery of healthcare.

Dr Toby Hillman, a consultant in thoracic medicine and acute medicine at University College London Hospitals NHS Foundation trust highlighted the increasing use of the technologies within healthcare. This revolutionizes the way data is generated and collected. He used the example of his smart phone and an app recording his route and physiological data during his journey to work on a bicycle! The question is, where next with these technologies?

The highlight for me was Professor Sir Harry Burns. He was up until April 2014, the chief medical officer of Scotland. He posed the question ‘Ok, so what shall we, each of us do tomorrow to make things truly better?’ He highlighted the complex relationship between socio-economic status and illness. This means that the solutions have to be geared towards addressing these disadvantages, if we really want a healthier population.

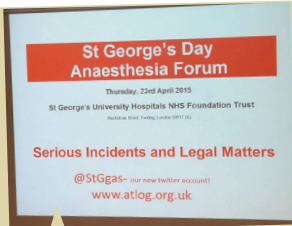
So the answer to the topical question of who is responsible is, - all of us! The responsibility starts early and is a lifelong journey between all those involved. So I ask you, what shall we, each of us, do tomorrow to make things truly better?

As a clinician, gaining insight from a patient’s perspective is always a humbling experience.

COMPLEX

Department

Picture News



Annual Anaesthesia Forum
A commitment to investigate
A need to learn



Training
Emergency undocking of *da Vinci* robot
(Dr Sarah Hammond & team)



Christmas Party
11th December 2015
Watch out for details

Caption competition



Prepare your caption (speech, thoughts or a general description) and share at the christmas quiz.

1. The most admired anaesthetist in the department.
2. ?

Transfer & Retirements



Ms Luiza Peries
Theatre co-ordinator achieves promotion and transfers to T&O as Assistant Service Manager.



Dr Jeremy Cashman
Senior leader (former associate medical director).



Dr Davinder Garewal
Consultant anaesthetist (airway & sedation guru).

Anaesthesia Clinical Services Accreditation (ACSA)



Our department is a member of the Anaesthesia
Clinical Services Accreditation (ACSA) scheme.

This means that we are committed to a standard of
good practice set by our professional body.

August 2015

www.rcoa.ac.uk/acsa