ANAESTHESIA POINTS WEST

AUTUMN 2019
Vol 52 Number 2

THE SOCIETY OF ANAESTHETISTS OF THE SOUTH WESTERN REGION

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Editorial

The potential negative environmental impacts of anaesthesia have steadily been gaining more publicity in recent months, and quite rightly so. Valentine and Swarbrick provide us with a neat summary in this edition, including some Think Green! top tips. There are several aspects of our practice under scrutiny and the onus is on us to work responsibly and innovatively to minimise these impacts. Of course, patient safety and providing the best care possible should, and will always be, our priority. However, I do believe we can make positive changes whilst maintaining excellent standards of care.

I am pleased to include three articles on this theme and it is great to see some of the outstanding work happening in our region. Perhaps we will all follow Exeter's example and have "Green Teams" in the future? In my own institution, following work led by a trainee, desflurane has become an "on request only" option. This is a sensible and pragmatic solution in my opinion and forces you to think about whether you really need it. Self and Eveleigh and the team from Exeter show that other simple interventions, such as raising awareness, can result in big changes in practice. I would be interested to hear about any other initiatives or projects happening around the region.

I am always very impressed with some of the interesting work colleagues do outside of the theatre and hospital environment. After hearing about anaesthetists in pre-hospital care in the last edition, this time Craig Holdstock gives us the lowdown on being a hyperbaric physician. I am keen to make this a regular feature so please do get in touch to tell us how you use your anaesthetic skills in other surroundings.

As always, our local wine guru continues to impart invaluable wine knowledge in these pages. This month we hear all about British wines. I was particularly pleased to see one of Perris's picks is in my neck of the woods and I will certainly be making a visit.

As the days get shorter and shorter, the fantastic Spring Meeting featuring sea, sun and surf (and some talks apparently) seem a distant memory. However, fear not, as the Autumn meeting is upon us with a fantastic venue and programme. Enjoy!

Johannes Retief - Editor

Future Meetings of the Society

Spring 2020
Truro
20-21 May 2020

Winter 2020
Exeter
Dates TBC

News of the West

This is where you are kept up-to-date on all the news and gossip from each department in the South Western region. The name of the correspondent appears at the end of each contribution and he/she is also the SASWR LINKPERSON for that department. Anyone wishing to find out about more about SASWR, or wishing to join, should search out the local linkperson, who will readily supply details. In addition to other benefits, each member will receive the twice-yearly edition of APW! Please also visit the new website (https://saswr.wildapricot.org) for loads of information and joining instructions.

Barnstaple

Greetings from Barnstaple, and thank you for your support for our SASWR meeting in June. I'm sure everyone will agree that the venue (Saunton Sands) pretty much sells itself. Thanks to all the regional speakers who contributed a huge amount to the content and flavour of the event. Apologies for anyone expecting the Thai diving incident who instead got a bloke who ran around the world.

Dave tells me that we have had a rather flat quarter with little in the way of slips, trips or gaffs, so little to report that might entertain. Tony Laycock is not up to his usual travels so no dodgy postcards from exotic locations. There was a department get together on Saunton Sands beach in July which involved surfing, running around on the beach and finishing off with a feed at Sands Cafe.

There are a whole group of new faces, some of whom I've yet to meet or work with. I have to admit I was off for 4 weeks in August cycling and hiking in Slovenia. I learnt that Slovenia is shaped like a chicken, has "love" in its title and is clean and beautiful with loads of trees and friendly locals.

I've met Edit (pronounced edit as in edit that document) from Finland - bright and friendly and organising a regional/national interview preparation course for trainees trying for Core Anaesthetic training. Ian Wilkinson, deliberate, friendly and built like a prop forward. Stuart Cooper, a gentle giant and Grace Friend, sharp as a meerkat (both ED ACCS). Rosemary (listen to teacher!) Hartley and Jamie (let me make this clear) Back are with us for another year for their sins. Adam Brayne, Emma Fisher, Peter Jackson, Duncan Kaye and Peter Mounstephen all too new for a one-line character assassinations from yours truly.

On the consultant front, Chris Smith and Gareth Moncaster have started work and both making significant contributions, transfers, SOP's, etc. Cery Redrif has been joined by Julie Harper-Simmonds and Denise Sheldrake to help with the various admin tasks of running and co-ordinating an ever-growing bunch of Anaesthetists.

Guy Rousseau

Bath

I write this version of the Bath update from the relative comfort of seat 5D on an EasyJet flight from Bristol to Genoa. Outside, it's lashing with rain and we've been delayed waiting for a crew member to replace a sick colleague. I'm looking forward to 5 days of cycling through Italy with some good friends and Ted Rees. I'd consider him a good friend except for the fact he tormented me on a long climb out of the Pyrenees two years ago when he and Tom Simpson chatted the entire time, in stark contrast to my effort induced respiratory distress. I hope to return the favour this trip, having trained quite hard, but more importantly having lost two stone in weight. For any non-cycling anaesthetists (surely an oxymoron?) being small trumps being fit on a bike climbing hills. Better to be both. Which is also largely true of having a general anaesthetic. We just can't say so too vociferously for fear of marginalising an ever-increasing cohort of western society.

I was intrigued seeing a recent advert for a course on CPEX and pre-operative assessment in one of our esteemed journals. I'm not renowned for being politically correct, but I did write to the editor questioning the use of a model who was young, slim, fit, clearly not in need of CPEX testing and as far from the overweight, unfit and older patient that I am usually presented with, sadly without the benefit of any CPEX test. I've not heard back, possibly because these days it is better to spin a good story with popular appeal than to tell the truth.

That aside, I am increasingly pleased to see accumulating scientific evidence, a fantastic book (Why we Sleep) as well as reporting in the popular press about the detrimental effects of a chronic lack of sleep. I was intrigued by an article I read recently about the sleep pods a nearby anaesthetic department purchased to facilitate some rest for their on-call staff. Their intentions are good, but as a substitute for a proper on call room, they must surely rank alongside 'chairport' as a replacement for a functioning day surgery unit.

Not a month goes by without another email from pharmacy warning us of the drug (suxamethonium/phenylephrine/ diamorphine) that is currently in short supply. Not a week goes by without an email from our increasingly beleaguered chairmen asking for people to volunteer for extra shifts to cover lists. And not a day goes by that I'm not frustrated by a lack of syringe labels, syringes, drawing up needles or whatever antibiotic I am most likely to hope to find in the drug cupboard when I arrive in the morning. And Brexit hasn't even happened yet.

In these trying times, what keeps me sane, is the fantastic colleagues (doctors, nurses, ODAs, ODPs, HCAs, and radiographers) that I work with. What keeps me amused, is watching Dr Kerslake navigate the trials and tribulations of everyday life.

We were sad to say goodbye to some fantastic trainees. Lucy, Alice and Olivia, Andy and Abby, Ben, Mark, Lauren,

Billy, Martin and Sam. Abby Harper traded the slightly moist environs of the West Country for the colder climes of rural India. We wish her well.

August has come and gone and our newest trainees have now settled into their time in Bath. It's great to see some old faces returning as registrars (Nick Harris, Laura Kettley), having first worked with us as SHOs some years back.

It is also a pleasure to welcome Pete Steed, who was with us as an SHO, a registrar and now joined us as a Consultant. Our erstwhile Commander has retired and returned and Dr Goodwin has also become a grandad (although his cycling attire would suggest he's been one for several years already). Congratulations to Ash on the birth of his second child and to Mark Sheils and Sam Howell on the birth of their first.

Thank you to Richard Edwards who put together a team to take part in the Cotswold Relay. It was one of the hottest days of the summer and I was grateful for having one of the earlier legs. Dr Jonny Price took it all in his stride as part of his preparation for an ironman (which was sadly cancelled) and we had a great day out. Unfortunately, despite some fantastic running (Chris Lawrence, a maxillofacial surgeon from SA) we finished behind our Bristol and North Bristol rivals. We might have placed slightly better had Ed Courtney been as good at navigating his way round the Cotswold Way as he is the colon. He managed to run further than required, in good time, but sadly in the wrong direction. He had the longest leg (before he added his own scenic detour) in the heat of the day and was definitely tired, sweaty and more than a little embarrassed when he eventually made contact. His efforts were nothing compared to those of Rebecca Leslie, one of our newest consultant appointments. She cycled 500km across Kenya from Nairobi to Meru, raising money to improve access to healthcare for mothers in rural Kenya.

We were fortunate to enjoy a beautiful summer's evening BBQ in the idyll that is Dr Thomas' garden. Awards were presented to Dr Mark Sheils (3rd on call), Drs Ben Savage and Lucy Corbett (1st/2nd on call) and Dr Alice Quayle (ITU). Congratulations to all of them.

I need to make a correction to my previous Bath Update, when I referred to Dr Kerslake as Captain Sweatpatch. Apparently, it should have been Major Sweatpatch. My apologies, Ian. I believe the reason he was so hot was his desire to get as much use as possible out of the expensive down ski jacket his wife thought he'd 'lent' from a friend. Or maybe he stood too close to the expensive new BBQ he purchased (again without prior approval from the finance department). Almost as bad as trying to get funding for that course you'd really like to go on…

Malcolm Thornton

Cheltenham and Gloucester

Greetings from Gloucester and Cheltenham! We welcomed another three consultants to the ever-expanding department with Sophie Scutt and Louise Sellar starting in the last month and Martina Nejdolova joining the ranks in January, bolstering the pre-assessment ranks and the birthing sheds, amongst other areas. A night out at the Giggling Squid in Cheltenham dined in our new arrivals. Great to have you guys on board and welcome!

Team ICU had their 'Big Day Out' in May with a 5km walk/10km run/50km bike ride in Saul. Docs, nurses, children and dogs raised a princely £3000 which we're assured are bypassing the Windsor Sausage Farm and going towards various ICU charities.

On the anaesthetic side (although Dr Foo snuck in somehow) a team of intrepid Anaesthetic, Surgical and ODP runners, took on the mighty Devil Mud Run. 'The Muddy Colons' managed the 10km course in a sedate 3 hours, although the waist deep mud, and multiple obstacles and an enormous slip slide provided significant challenges. Although we harshly dismissed Dr Knight's hurty finger half way round, he later revealed that he had in fact fractured it. All back intact now thankfully. Remarkably no further injuries to report although most of us are still finding mud where we didn't know mud could reach….

On the trainee side we continue to be blessed with high quality. Congratulations to Matt Higham who managed to persuade a lovely lady to marry him. Congratulations too to Alice Bevan who passed her primary FRCA and two weeks later tied the knot with Ed Tudor of urology fame. All the best to both. Tish Orsman also became primary positive and Oli Barker secured a well-deserved CT1 post. Many congrats to both.

Finally, in our regular feature, the Hunton injury update, apparently a return to the pool after a prolonged hiatus, 130 lengths and 'too many tumble turns' isn't very good for the back, Quasimodo is thankfully on the road to recovery.

Have a good Winter all.

Sam Andrews

Exeter

Somehow, we have survived the summer once again. We were fortunate that Nicki Ross joined us as a locum, and Colin returned from Nigeria just in time to help out, but as always, it's a relief that the leave season is over. We've had the usual change over of trainees. We wish all the departing people good luck in their new posts, and welcome to the new, or not so new, arrivals. It is always lovely to see old faces, but it is also a reminder of the passing years to find our previous SHOs returning as accomplished anaesthetists.

James Cockcroft has taken over from Kath Meikle as college tutor, and Kath has taken over as TPD from Emma Hartsilver, and Emma is just swanning around enjoying herself! Pete Ford has been appointed Trust lead for Illusion, or as he calls it Innovation. Well done, and I wish Pete success in the role, even if it sounds like a spoof role in a spoof TV show. Sadly, it means Pete will be reducing his anaesthetic sessions. Thanks to Simon Marshall for taking over from Pete as airway and equipment lead. Congratulations to Zahra and Alec on the birth of baby Leon, to James Cockcroft on the birth of Emily, and to Shun for his new arrival.

This year Kath Davies and Jeff hosted the summer party at their fabulous house with views over the Exe estuary. The weather was more than kind, and there was a good turn out. The pizzas were delicious, and of

course Paul Thomas's homebrew was up to its usual standard. Fiona Martin masterminded an unusual rendition of Bohemian Rhapsody, sung by Helen Gilfilan, with the entire Martin family providing backing vocals, and John Saddler played a lovely acoustic set.

MyCare is moving on at pace. It is reassuring to know that everything that is less than ideal at present will be solved within weeks of the MyCare launch. In truth, while I fear that the teething troubles will be many and painful, I am looking forward to the opportunities which all this easy access to data will afford us. The downside is that several of our older colleagues are planning to retire rather than have to endure such an epic (pun intended) change in how we work.

We have had a good deal of recent exam success. Well done to Aiden Melia for passing the Final and to Matt Baldwin for passing the primary.

I think that's all from me, and Exeter, for now.

Pippa Dix

Plymouth

Whilst the rest of the hospital has been at supra-winter levels of business, the focus of the summer holidays has caused a period of calm and a lull in the gossip in the anaesthetic department. Part of that calm has resulted from the realisation that we can't continue to plug the gaps without potential requests from the less than benevolent taxman to contribute to the new hospitals elsewhere in the country. There has been a mixed response to this, and some individuals' charitable leanings have been tested to near breaking point.

Fortunately, Tom Bradley arrived to take up his consultant post in June and has been striving to plug all of the gaps, particularly in the far flung out of theatre areas. He is a brilliant addition

to the department and was welcomed with open arms. Dave Adams as SLD recognised that Tom wasn't managing to plug all of the gaps and that we needed some more additions to the department. There were brilliant applicants for the jobs and, to much excitement in the department, it was announced that jobs had been offered to, and accepted by, Lauren Weekes, Lindsey Arrick, Tori Field and Tim Warrener. It dawned on us slowly that this may not improve the extended work opportunities on offer for a while. Lindsey was going to transition from locum to substantive consultant, but quite rightly decided to have a long holiday first, Tori was going to enjoy her maternity leave before the need for more adult conversation (she may be disappointed) drove her back to work. We are eagerly awaiting the arrival of Tim and it was a delight to once again hear the soft voice of Lauren in The Back Bar, gently shaping our thinking. I am not sure what message the lack of photo on her initial ID badge sent, but it is a relief that she hasn't developed further super powers that included invisibility. She now has a photo on her ID card that does more to suggest permanency and legitimacy.

As Dave Adams handed over to Justine Elliot, he assured her that there were sufficient anaesthetists coming to plug the gaps that she should let Richard Struthers and himself apply for different management jobs. Dave, having had such a relaxing time as SLD, has been appointed as the Care Group Director of Medicine which throws up the interesting challenge of how he maintains the illusion that he can try to tell his wife what to do at work, when he has long since given up any attempt at this at home. Having solved all of the problems in the Surgical Care Group, Richard has been appointed as Deputy Medical Director for GIRFT and Productivity. It is a relief that the rise and influence of anaesthetic pragmatism and common sense continues and will shape the future of Derriford. To make it clear to all, Justine is still their boss.

There have been reasons to celebrate as Helen Marshall (plus Lexie Humphreys and Pippa Squires) won AAGBI trainee wellbeing initiative award for SCREAM. This is a fantastic achievement for the region as we seek to look after and support each other. There have also been exam successes with Chris Pritchett, Harriet Daykin, Ben Whittaker and Juleen Fasham passing the final FRCA in the summer. Congratulations to them all.

Further quantities of champagne were also ordered to celebrate the arrival of a baby (boy) to Zach Jeffrey in August, and import routes are being explored to ensure that there will be enough champagne for the wedding of Andrew Biffen and Bex Johnson after the (very quiet) announcement of their engagement.

The churn of life continues and there are rumours that senior stalwarts of the department have identified more interesting ways of filling their time, and some have mysterious apps that appear to be counting down to an

event that brings a smile to their face when they are asked about it. There are likely to be some big gaps in the department as these players head off to enjoy life outside the hospital…

Matt Hill

Swindon

No news is good news except when you've got to write the column for Points West. Running through the list of anaesthetic staff with Karen, our PA/ matriarch, we realised that, aside from comings and goings, there is pretty much no news!

So, let's start with those comings and goings. Too many trainees have moved to mention them all but I must include 'Professor' Jonathan Barnes who has become an ST3 in Bristol after sterling work at Swindon, first as a novice and then as innovation fellow. Another Swindon novice, Vicky Hawley, has taken her cats to Nottingham where I'm sure her cake baking skills will be appreciated. New to us are locum consultant husband and wife team Jamie Biddulph and Alex Day who have moved down from York.

In my efforts to get some news from the regular crew I sent out a group email which was, as most group emails are, ignored. Undeterred I sent out a survey monkey questionnaire. This at least got some response - a grand total of 8! This revealed that 75% had a fantastic summer holiday but 25% admitted it was disappointing or could have been better. The majority (62.5%) feel they have achieved something significant at work but on further probing is seems that 'surviving' and 'still seem to be alive' rank as being notable. A similar amount (62.5% again) have achieved something significant at home – keeping pets alive and watching Netflix featured highly.

This apparent lack of enthusiasm has made me wonder whether we need to implement a quality improvement project to look at staff welfare. We spend all our time working in a system which aims to improve the working of the hospital without addressing the wellbeing of the staff. Our WHO checklists make sure equipment is working well but the staff only have to be present. I wonder if we would care for our staff better if we had to rate our enthusiasm and wellbeing at every theatre team brief? Of course, it is only worth measuring something if you can actually do something about it!

Ed Bick

Taunton

Another newsletter and it seems like only yesterday since I wrote the last so now comes the challenge of creating something interesting and amusing for us all to peruse over the breakfast table/anaesthetic machine. Or perhaps, as Ian Davies suggested, I should just stick to facts and where that fails intersperse fiction as best I can.

Firstly though, some Somerset pride should be taken from the fact that Musgrove Park is the happiest place

to work if you're a trainee. We ranked top of the Severn Trusts for trainee satisfaction in the most recent GMC survey. Credit to all of those working here who have helped that happen. Given that we are keen to increase our permanent staff numbers, I encourage all satisfied and unsatisfied trainees to come and visit us if you're interested in working in the county capital's hospital! We did also host the Cricket World Cup too…well at least some of it.

Inevitably, the summer has brought a number of farewells and of greetings to old and new members of the department. We were sorry to say goodbye to an excellent group of trainees in July and were glad to be able to celebrate with a BBQ and drinks at the Winchester in Trull. Regrettably, it seemed that there had been a dress code of salmon pink shorts and blue t-shirt decreed by one of the senior members of the department (see photo). Rather than being appalled at all arriving in the same outfit in one of the biggest fashion faux-pas of the year, the motley group joked and were even keen to have photographs taken together. Naturally these have subsequently (and mysteriously) made their way onto the department wall for prize-winning captions.

Now that funding for the third tier has been agreed the department drive for producing babies has finally settled and the labour ward has breathed a sigh of relief. Not least because we seem to be down to our final ampoule of diamorphine. This has prompted departmental discussion over the best person to take a trekking tour around the Afghan countryside in order to find a reliable provider in a potential post-Brexit apocalypse. Current incentives include an extra 0.0125 SPA, limited study budget and plenty of amusing anecdotes of 'what-happened-in-UK-customs-on-my-return'. Certain members of the department have a more urgent and vested interest in this than others. Enough said! All that aside, congratulations to Charlotte Beresford who safely had a baby girl at the beginning of the summer.

We welcome trainees to the department and returning Andy Savva, Stuart Frankland and Carmen Marginean (just briefly since she's secured a cardiothoracic fellowship at the Brompton – well done). We hope that you enjoy your time in MPH and look forward to working with you. Madhavi

Keskar also started her permanent position here in August, much to the relief of the rota-writers and, fresh off the press, we have just appointed Helen Pawson as a consultant. Sadly, we are going to have to say goodbye to Adam Hatalyak who was successful in his application to a consultant post in Weston-super-Mare and Janos Mayer who has secured a consultant post in Worcester. We have very much enjoyed having them both in the department and wish them all the best with their substantive posts.

In other news, junction 25 on the M5 is undergoing a major redevelopment slowing all traffic coming off or getting onto the motorway. Consequently, any surgical emergencies around the region would be much better continuing their journey North/South in the middle of the night. This is predicted to continue until Summer 2021. And finally, there is a new railing obstructing a short cut between CDS and M&S causing some consternation with some (one) of the regular obstetric anaesthetists. This is beginning to feel more and more like our village magazine but I promise that I just write the big news – thank you for reading!

Tom Barrett

Torbay

Summer in the Bay has been a glorious affair with warm seas and lots of opportunities for outdoor fun. Problems with our theatre infrastructure continue but are hopefully improving although a momentous day of total hospital and local IT failures made the national news and gave a few people a few more grey hairs. Ageing fax machines apparently.

Our social events included a departmental summer pizza party at John Carlisle's Moorland home, the Tuckenhay paddle and joining the Burgh Island swim which were all hugely successful and well supported.

In terms of trainee transitions, we have waved off Rebecca Dyar, Will Hare, Sarah Shaw, Jen Moran and Drew Weir to their new ST jobs and also said goodbye to Dan Paul, Ben Whatley, Alistair Joyce and John Taylor. Of course, Tori Field wins the award for most dramatic departure with her efforts of popping out her second baby Oliver, and interviewing for a consultant job on the same day (well pretty much anyway). We welcome Gill Barnett, Matt Boyd, Lou Cossey, Anna Ferguson, Vicki Lewis, Bex Johnson, Tammy Lane and Will Spencer onto the SpR rota and Tini Christodouli, John Clouston, Ginny Francis, Hope Raybauld and Mike McGovern onto the CT rota. Recent MCQ success has been secured by

Jon Carter, Greg Warren and James Womersely. Great work!

Rachel Remnant, who we are lucky to have with us for another year, got married this summer on what sounds like a magical day and then nipped off for a combination of wine tasting and Disney for part of her honeymoon - sounds fab! Congratulations also to Johannes on the birth of his little girl Phoebe and to Tom Nightingale and Anna for the birth of Tabitha. Both of them are absolutely gorgeous.

Hot off the press two consultant appointments have occurred since last writing with both Lexie Humphreys and Tom Nightingale securing well-earned substantive posts. David Levy has arrived to take up his post and boost our POM team and David Hutchins has started as a fabulous addition to the pain team.

After many years of committed service to anaesthetics, paediatrics, bariatrics and ITU (to name but a few), the multi-skilled Sarah Jane Fearnley will be hanging up her clogs in December. Also leaving us will be Louise Robinson who, in addition to anaesthetics, has been hugely influential not only in allergy testing and ECT but in her role as Chair of the LNC. They will be very sadly missed in the department - more details to follow about their careers (and retirement parties) in the next edition.

We continue to be very proud of our 'data sleuth' John Carlisle who has been published in Nature this year.

We are happy to report the safe return of our round UK sailing expedition team Katie Flowers (Skipper) and David Snow (previous sailing novice and chief cook) who purchased a boat and set off around the British Isles this summer. Well, why not? Several members of the department with varying sailing expertise joined them on different legs of the trip. Both Katie and David returned looking fresh, fit and 10 years younger (at least!) - there was much jealousy all round.

In other sporting news, Andrey Varvinskiy continues to go from strength to strength with incredible performances in triathlons and iron-men all around the UK and Europe. Louise Webster performs remarkable feats on her bike with some awe-inspiring tales from an elite cycling event in the mountains of Europe. Meanwhile, David and I continue to ponce around in a different kind of lycra in our spare time, most recently dancing (a lot!) and singing (quite a lot) in a local production of CATS. Yet again, once the photos are seen, they can't be unseen!!

Theresa Hinde

Truro

Guest authorship this month as our dearest Becky Brooks has taken advantage of our sabbatical program and is currently cycling the world – literally. She has recently completed The Great Divide [www.the-great-divide.com] and The Sierra Cascades - cycle routes across North America that will inspire many of the middle-aged lycra clad colleagues referred to frequently in these pages. Becky is taking a short break from the bike to sail to Vancouver and the Islands and then has her sights set on New Zealand and Australia. No doubt Milford Sound to Bay of Islands to Darwin and back again for good measure. We wish her well and can't wait to hear of her adventures next year. You might have wished for the wit and charm of Georgia Brooker, an experienced scribe of these tomes, but she is busy building the SASWR 2020 program, which is looking to be a wonderful conference – and venue of course. We look forward to hosting you all.

I can update you on Zoe the Beast, although I can't recall referring to her in such terms. Our commercial coffee machine, pride of place in

our resource room, has been given many other terms. The bacterial cultures produced, the caffetiere and instant and bean to cup proponents' and afficianados' expressions, have entertained those who haven't 'left' the WhatsApp communities. Speaking of which, Lewis Connolly has not only applied himself to a magnificent overhaul of the CEPOD electronic booking system which has improved all our lives, but has also produced a comprehensive analysis of the departments WhatsApp usage. There are some clear social media addicts! Perhaps we shall leave it to SASWR 2020 to present a special award. We may run a sweepstake of the top abusers.

Distracted by the constant bings, I forgot to offer appraisal of coffee from 'Zoe'. As the cost per cup for the original fools hoodwinked by Ben Warrick into the capital purchase, is reaching single figures, the coffee is tasting mighty fine; a wonderful supplement to Tom Bevir's breakfast club acadaemia sessions. These are proving so popular that competition is likely to be fierce again for the award of Presenter of The Year Lanyard.

The Resource Room is a great venue to refresh from our most recent Welcome Curry. At Shanaz, Truro, we managed to ensure Chris Smith's attendance this time, and also welcomed anaesthetists Hanneke Heynen from Holland, Mark Lambert from the Royal National Throat Nose and Ear, and our very own Carlen Reed-Poysden [is that CRP or CPR?]. In addition, the curry celebrated the arrival of Taz Zee, James Masters and Nicki Jannaway, as we have expanded our service manager team to support the growing department and ACSA future.

Mention of the future and you may have noticed the £100 million investment, showcased by our current prime-minister. Authored before October 31, this is the biggest ever single investment Cornwall has seen in local health services. We watch and wait with hopeful expectation. The plans are certainly in process for a new maternity unit and women and children's services theatre suites. I'm equally hopeful this phase of Cornwall investment may see the completion of an iconic stadium for the people of Cornwall, ground capacity for 6000 spectators, but the facilities

that will enhance our capability to host international performers and international conferences.
Writer's block and I'm pondering why I didn't persuade Nick Marshall to throw humour to the page, but I realise he is engaged delivering the final phase of his expertly delivered double term of College Tutor, and planning a 6 week extended leave mini-sabbatical. The latter will be well deserved and give him the energy to embark on his next project. A new Post Anaesthetic Care Unit. I'm even more hopeful that Boris' Bung becomes a reality.

Climate is clearly a lead agenda, with our own colleagues, though not yet anaesthetic, embracing Extinction Rebellion. Whilst declaring that we've become 'Desflurane Free' to save the planet, might be disingenuous, we are revelling in our engagement with SageTech to develop volatile recycling. Which is Brilliant! A term that may be getting a little, well intentioned, overuse in these parts. We have our very own Brilliant Festival at Scorrier House. And a plethora of Brilliant – there it is again! - Awards. And some Brilliant Leadership programs. Nevertheless, not wanting to miss out on the Brilliant fun, our man of action Ben Warrick has been nominated Brilliant Innovator of the Year. In seriousness his work as Trauma Network Lead, and Major Trauma Consultant rota implementation, has been inspirational. I'd present him his award in person, but I think he's off on a bike, or was it a kayak, or maybe some ropes!

Chris Pritchett deserves a mention too for his tenacity and perseverance to introduce the Thromboelastography to Cornwall. Along with the evolving EEG waveform expertise brought to the fore by the 'Dimpel Disciples' Simon George and Sam Spinney, and the expansion of CPET with Carlen and our new Pre-Op Anaesthesia Lead Tom Blincoe, and there's a lot to learn to keep up, for those of us in the last phase of our careers. We are revelling in the challenge.

Moving from those in the twilight of their careers, intellect fading through natural decay, I can congratulate those members of the department who can look forward to several years of sleepless nights and distracted anaesthesia, with the baby arrivals of Lola (Libby Fontaine), James (Tom Bevir), Andrew (Lara Herbert) and Florence (Ben Parish). I've only yet met one of these newborns in the local pub. I hope to ensure that I discharge my Director duties professionally and ensure Lara has a highly professional return to work interview in her chosen maternity leave venue … Flaine! I

might enquire of HR whether I can do ‘reverse keeping in touch days’. I hear they are very much part of modern HR culture.

Ben Parish also to be congratulated for Primary FRCA success along with Alex Lomas and Adela Dobru. Final FRCA success congratulations to Chris Pritchett, Sam McAleer and Kate Palmer. (We are missing her already.)

Life certainly moves fast. It is a delight to see colleagues who we recall from their novice basic competencies, witnessed them through their exam successes and now see them at the threshold of consultant careers. We are delighted to have shortlisted Simon George, Danny McLaughlin and Katherine Sprigge for forthcoming consultant interviews, and Suzanne Benhalim and Mikey O’Connor for post CCT Fellowship Years.

The weather has started to turn, so the boats are slowly returning to their winter homes, but with wind and weather comes greater surf for our more committed less fair weather surfers, and in the distance the call of snow. We look forward to meeting our South West colleagues across Tignes, Val D’Isere and St Anton, and remain committed to the high-quality conference provision therein. Few conferences match such opportunity to develop professional fulfilment and personal wellbeing. I’ll be looking forward to meeting existing friends and colleagues and developing new relationships in the snow with potential applicants for our Spring and Autumn 2020 consultant interviews.

I’ve been called to proof read the signage for the new Cornwall Department of Anaesthesia and Peri-Operative Medicine, so I shall have to close. I suspect that’s a project that will grow and grow. I am thrilled to oversee the return of beds for trainees overnight. Anyway - more of that in the New Year. With a new guest author! I’ve just got to devise a method of selection.

Gary Matthews

U H Bristol

Greetings from UHB. I’ll start with the big event of the last few months: Frances Forrest has left the building. After many years dedicated service to the patients of Bristol, Dr Forrest has completed her final end of list debrief and from recent

WhatsApp activity appears to have gone native somewhere in France. Perhaps she's made a break for it pre-Brexit. Her career at UHB has taken a wide variety of roles over the years including CD, Revalidation lead and Trauma lead. Although she will perhaps be missed more in her role as a friend and mentor to many of us in the department. Over the years her wise words and experience have guided many a junior anaesthetist and she will be sorely missed. She bowed out in style at the Avon Gorge Hotel where hundreds turned out to wish her well including video messages from friends and colleagues past and present who couldn't make it. Neil Muchatuta compered a This is Your Life presentation and the dancing (The Dellstars providing the music, who else?) was impressive (Adam Duffen performing a wild lift then immediate drop on Helen Caine was a particular highlight). Her hat by the way (see photo) incorporates things she's keen on – wine, gardening and all things French I think.

We have welcomed two new substantive consultants to the department, Stuart Younie and Anoushka Winton. They were 'dined in' in style at the River Station where Anoushka pointed out in her speech that she's had two babies since she first became a locum consultant at the BRI. I don't think the two things are linked. On the subject of babies, they are coming like busses – Drs Hood, Younie and Gupta all added to the tally in the space of a few weeks in August. We also welcome Helen Howes and Sarah Waricker as locum consultants. On the other side of the ledger we have lost Sophie Scutt to her new substantive post 'up north' in Gloucester. Our loss is their gain.

Our valiant CD Nilesh Chauhan recently asked the whole department if anyone wanted to take on the role from him…So I'm pleased to say that he is now looking forward to his next 3 year term as I write.

Our large number of trainees and clinical fellows continue to work hard and do a fantastic job despite all the pressures of the modern age. The only problem I have nowadays is remembering who they all are as there are loads of them and they move every 3 months! It might just be the fact that I am now in my 40's.

In other news, Kaj Kamalanathen has just returned from a visit to China where they showed him the meaning of efficiency in thoracic surgery. 8 VATS, 5 lobes and 3 wedges per list, no bed issues and trainees work 7am-10pm. Every day. Come the revolution

no doubt the BRI will be similar.

See you in Bristol.

Ben Gupta

Yeovil

It's been a time of change and a time of sadness in Yeovil. We have welcomed two new consultants, but we have lost a friend and a valued colleague in Brian Swanton.

Firstly we welcome our two new consultants both of whom started over the summer. Dr Ciprian Cociuba, originally from Romania, who has been working for several years at Dorset County Hospital, and Dr Rob Bruce-Payne who has been working in Bermuda since his CCT several years ago. Both have settled in well and are a big asset to the department.

Yeovil is, and always has been, a small and friendly department. We are a close knit group of anaesthetists. So it was a huge shock to us when we received the awful news at the end of June that our colleague Brian Swanton had collapsed and was in intensive care in Taunton. Brian joined the team in Yeovil in 2010 having previously worked as a consultant in Ireland and Boston, USA. He was one of those that could most definitely see the wood for the trees and could always provide a valued and sensible opinion for matters both clinical and non-clinical. He was immensely experienced and a hugely popular member of the anaesthetics and theatre team here. Brian had come to work in Yeovil because he married Lucy, a girl from South Somerset. Together they had a son Conor who is now 7 years old.

Tragically, hours after he had just dropped off his campervan for a weekend to be spent with family and friends at Glastonbury festival, he suffered a cardiac arrest whilst out running in his home village of Lovington. Despite being successfully resuscitated by bystanders and then paramedics, he unfortunately never regained consciousness. He died, aged 53, on July 2nd in Musgrove Park Hospital ICU. We, along with Brian's family, are extremely grateful for the professional care that he received there.

Brian Swanton

These are big shoes to fill, and we are now in the process of trying to ap-

point a new consultant to be Brian's replacement. Recruitment remains a huge challenge in a department that does not have any senior trainees. For both our middle-grade and consultant vacancies, we are very reliant upon applicants from overseas. Despite always having great feedback from our CT1s we appear to have been forgotten about by the time that these anaesthetists have spent 6 or 7 years elsewhere gaining their CCT.

The villages and towns of South Somerset and North Dorset are beautiful and are great places to raise a family. Yeovil Hospital Critical Care, despite being relatively small, punches well above its weight in terms of outcomes, as evidenced by our recent ICNARC data which is amongst the best in the South West if not the country. Our anaesthetic department offers a good variety of clinical and non-clinical workload. So, for any of you senior trainees reading this, if you are looking for a new challenge somewhere that is relatively inexpensive to live, with good schools and easy access to some of the south coast's most beautiful beaches and seaside towns – keep your eyes peeled for adverts on NHS jobs and the BMJ. We need you… but maybe you need us too!

Joe Tyrrell

Report on the Society of Anaesthetists of the South West Region Spring Meeting

Saunton Sands Hotel, North Devon 22-23 June 2019

Dr Pippa Dix, Honorary Secretary

Before I make my report on the excellent spring meeting at Saunton Sands Hotel, I would like to make a correction to my report from the autumn meeting in Bath 2018. I failed to address all the speakers by their full titles, including several renowned professors. In addition, I did not make it clear that the Humphry Davy speaker, Professor Carol Peden, who previously worked as a consultant anaesthetist in Bath, had kindly travelled from California, where she now works as Professor of Anesthesiology, at Keck School of Medicine, University of Southern California, Los Angeles. In addition, Professor Peden holds the posts of Director, Gehr Center for Health System Science and Innovation, Keck School of Medicine, University of Southern California, Los Angeles, Adjunct Professor of Anesthesiology, University of Pennsylvania, Visiting Professor University of Bath Business School Center for Healthcare Innovation and Improvement, Senior Associate Tutor MSc. in Surgical Sciences, University of Oxford, Vice Chair American Society of Anesthesiologists Brain Health Initiative, Vice President International Board of Peri-operative Medicine, Board Member International ERAS Society (USA) Consultant to the American College of Surgeons Improving Surgical Care and Recovery Program Institute for Healthcare Improvement Fellow and Faculty Health Foundation Quality Improvement Fellow and "Q" Fellow and Harvard School of Public Health Innovator of the Year 2016.

The 2019 spring meeting was organised by North Devon District Hospital (NDDH), ably led by Guy Rousseau, with help from Nigel Hollister, Dave Beard and Gorki Sacher. The meeting was well supported, with a final delegate number of 120, and many people bringing their families and staying for the weekend. And the weather was fantastic for both days. The view of the beach from the lecture room is second to none. The only problem was trying to coax people back into the meeting from the terrace after the breaks.

Dr Guy Rousseau chaired the first session on Thursday, entitled Communicating Pain. The first speaker, Dr Lucy Miller, chronic pain lead at NDDH, spoke on motivational interviewing (MI). MI is based on Yoda, and Jedi skills, believing that your strength lies within, but you need to find it. MI uses collaborative

conversational skills to change behaviour, and is used in elite sport as well as health (as well as on most husbands). Change is hard, and we know that traditional advice, to stop smoking, lose weight, eat healthily, etc only works on about 1 in 20 people. By using open questions, affirming strengths, reflecting and summarising, people can change.

Dr David Beard, consultant anaesthetist and former pain doctor at NDDH followed, with 'Morphine is not a Painkiller'. This was his final lecture on pain, now that he has given up pain medicine. The traditional nociceptor pathways don't explain pain. Our brain interprets pain, but it is not related to any actual (or sometimes any) tissue damage. Distress is more important than tissue damage in the perception of pain. The use of the term painkiller is very negative, as it creates huge expectations of the effects of analgesics, especially opioids. We should think about using terms such as pain medicines or pain-relieving drugs. Instead of scoring pain out of 10, we should score the impact on function (eating, sleeping, moving, coping, etc.) out of 3. His recommendations on the principles of analgesia are to treat the underlying pathology, use physical analgesia (hot, cold, elevate, massage, move), use intelligent pharmacology (e.g. LA, paracetamol, NSAIDs for inflammation, a healthy dose of opioid, then use something else if pain persists), and address the patient's distress. Given the global epidemic of opioid misuse, we need to reduce the opioid culture and prescription expectation, and learn to suffer and get on with life.

After the coffee break Dr Simon Hebard chaired the next session, 'Perioperative Medicine in Action'. The first speaker, Dr Sheena Hubble from the Royal Devon and Exeter, spoke of her experience as a perioperative physician. Worldwide, postoperative mortality is the fifth commonest cause of death, accounting for more deaths than diabetes. We are operating on increasing numbers of patients, patients who are older and frailer, and more operations are performed as emergencies. Of general surgical emergencies, over half are managed medically. A third of patients aged over 70 who have an emergency laparotomy are dead within 3 years. Currently junior surgical trainees provide the ward care for these patients, with limited access to senior medical input. Complications are stepping-stones to poor outcomes. Most complications are medical and have a high mortality. For example, the mortality from AKI is the same as from an anastamotic leak (10%), but doesn't generate the same interest from the surgical team. Complications result in lengthy hospital stays, and patients never regain their predicted preoperative mortality. In her role, Sheena joins the surgical ward round, which prolongs the round, but helps to pick up complications early. Her outcome data have demonstrated a fall of about 50% in the number of MET calls, reduced mortality and length of stay for patients after laparotomy and pancreatitis, reduced AKI and gentamicin misuse, reduced emergency medical registrar referrals.

Dr Mike Swart from Torbay followed, speaking of his experience of perioperative medicine within the Royal College and in Torbay. From a college perspective he discussed day case total hip replacements, which is only performed in a few hospitals, often in the private sector, but on NHS patients. Patients need to be selected and motivated. There is potential to do more day case surgery, including more THR, caesarean sections, and emergency surgeries, such as abscesses, laparoscopic appendix, ERPC, etc. Opioid management is important, both identifying patients preoperatively, and following up post operatively, with referral to pain management if necessary. There is a new Centre for Perioperative Care, which sits within the RCoA. The initial focuses will be diabetes, day surgery standards, day surgery accreditation, and enhanced recovery standards. There is a need for enhanced care, as currently 85000 patients per year are cancelled on the day of surgery due to lack of a critical care bed. Most of these patients don't need level 3 (ITU) or level 2 (HDU) care, they just need more than the ward can provide. This is enhanced care or level 1.5, with a higher nurse to patient ratio, increased monitoring including arterial line and blood gases, and ability to administer vasopressors, amiodarone, magnesium, etc. In Torbay they have had a trial period of enhanced care. Consultant anaesthetists, supporting the F1 doctors, physios and OTs, have mainly led this. Now they need to find the money to continue. A question from the floor asked whether there was a plan to increase the anaesthetic work force, if anaesthetists are doing more perioperative work. The answer is no, but PAA might be part of the solution.

During the lunch break there was an opportunity to visit the many trade stands, which had generously supported the meeting, and also the large poster exhibition. Plus, there was the opportunity to bask in the sunlight and take in the stunning view.

Dr Jeremy Preece, from NDDH, chaired the first session after lunch, 'Standardising the Acute Laparotomy'. Dr Gareth Moncaster spoke first on his experience of NELA from another region. He has been a consultant in Sherwood Hospitals Trust, but is about to take up a post at NDDH. Sherwood is a moderately sized DGH with about 150 emergency laparotomies per year, and found itself performing badly in terms of outcome after emergency laparotomy. About 5% of cases had no consultant surgeon or anaesthetist, or an ITU bed. Initially they made easy changes to the data collected by NELA. In 2015 they joined EPOCH, and started to use process mapping, PDSA, run charts to promote change and private emails to flag up which steps people were omitting. Disappointingly, no survival benefit was shown, although the methodology had positive effects for other emergency services.

Dr Matt Hill, from Derriford then spoke about regional improvement collaboration. As part of the SW

Academic Health Science Network, he has been involved in standardising care for the acute laparotomy. His advice is not to like your team, but to love them like your family. He compared the approach of NELA, with 6 aims based around care and safety, with the Emergency Laparotomy Collaborative, which tells you 6 steps to take. The Best Practice Tariff pays a higher rate if the care delivered is considered best practice. Best practice is for 80% high-risk patients to have a consultant anaesthetist, consultant surgeon and an ITU bed. For the first 3 months of this year, the rates were 40% Derriford, 85.7% RDE, 100% Truro. Changing practice is less about technical detail and more about involving the team.

Dr Gorki Sacher from NDDH chaired the final session of the day, ITU. Mr Richard Barns told his personal story of developing necrotising fasciitis and coincidental leukaemia. His family were told he would die, but he survived after 6 weeks on ITU and 2 further months in hospital, and a leg amputation. He regained consciousness in time to see England being knocked out of the world cup. He was shocked by how quickly his muscles wasted, but now can walk 6 miles with crutches, including on sand, he has a prosthetic leg, which means he hardly uses his crutches, and is able to drive. He is very grateful to NDDH for the care shown to him and his family, and is currently fund raising for ITU.

The final speaker of the day was Dr Martin Cook, intensivist at Salisbury Hospital, speaking about the Novichok poisonings. To set the scene, he described Salisbury and the hospital – small, quiet, nothing happens. A recent headline in the local paper was about a dog with a bruised nose. When Sergei Skripal and his daughter were admitted to their ITU, nobody suspected poisoning by a nerve agent. A Google search revealed that Sergei Skripal was a Russian double agent, and eventually they became suspicious that a nerve agent was the cause. Blood samples sent to Birmingham confirmed very low cholinesterase levels. A teleconference team was set up in Salisbury, with remote team members, including people with poisoning expertise. People are symptomatic with less than 5% cholinesterase activity. The plan was to raise levels by 1% per day, meaning that recovery would be slow. The principles of management were to decontaminate the patient (wash and dry), titrate high dose anticholinergics against heart rate, use oximes to reactivate cholinesterase, benzodiazepines to reduce fitting and possibly offer some central neuroprotection, and possibly propofol is also protective. When a third case was admitted a few days later, although they stabilised with standard treatment and recovered quickly, this raised concerns about the possibility of further cases, and whether they should stay in Salisbury. However, the feeling was that in a small hospital security was easy, and Porton Down is nearby. The first 2 cases were discharged after 37 and 73 days respectively. Then 2 more

cases were admitted, who were unconnected to the first 2, but had similar symptoms. Testing confirmed novichok, and the previous experience guided management. Although 1 patient died, the other recovered and was discharged much more quickly than the first 2 patients. During and after the event, there were lessons learned. The major incident structure allowed the media to be managed, and the clinicians to be protected. It was a challenge for the ITU staff to care for other patients while these patients were on the unit, and it was also a challenge to care for staff members, with constantly changing advice and media stories. Security was a priority. No phones were allowed, and staff members were involved only on a need to know basis. The fact that the hospital still uses paper notes reduced the worry about hacking information about the patients. Importantly, no staff members were affected, and they managed to get a new ultrasound machine from the event.

The Society Dinner was held at the hotel, with music provided by the Dellstars, on the first and only gig of their first, and possibly only, tour. The dance floor was full, and as far as I know, nobody was injured.

Friday was another warm and sunny day. Some brave souls were up early enough for a swim or surf before the day began, with the first session, Paediatric Anaesthesia and Anaphylaxis, chaired by Dr Rob Conway from NDDH. Dr Anthony Bradley from Bristol Children Hospital provided a paediatric update, with a roundup of what's new. In terms of research, work is ongoing on the use and effects of clonidine, dexamethasone, tranexamic acid, TIVA models and general anaesthesia and the developing brain. He discussed several clinical situations, starting with the use of IV or inhalation induction for a child with a difficult airway. This should be based less on your comfort zone, and more on whether the child will tolerate 8% sevoflurane. If the child has sepsis, cardiovascular instability, etc, then you should choose an IV induction with inotropes as required, with the difficult airway algorithm available and followed. For a child with bronchospasm, his tips were to check your ETT, use sevoflurane, increase the inspired oxygen, nebulised salbutamol, IV magnesium, call the paediatricians and WATCH. The ventilator strategy should be to oxygenate, ventilate enough and avoid dynamic hyperinflation. Keep PAPW below 50, as the plateau pressure will be lower, keep minute ventilation low, as this is the key determinant of hyperinflation and keep the rate low. Think about expiratory time, and live with hypercapnia, as neurological and cardiac complications are rare. Use the biggest ETT possible; PEEP might make things better or worse. Aim for a pH of 7.2 or better, if possible. The final clinical situation was how to stabilise an unstable child for induction, when they are not fit to transfer. Use the WATCH chart, and try to optimise as much as possible, using fluid and peripheral adrenaline, have bolus adrenaline available, fluid boluses available and a finger on the

pulse. Use ketamine, rocuronium and fentanyl. Remember the glucose, and don't get distracted by the fact that it is a child.

Mr Mike Saunders, ENT surgeon at BCH spoke next on paediatric airway obstruction. Most difficult paediatric intubations are associated with retrognathia. Jet ventilation is probably not useful in children, and awake fibre optic intubation is not usually possible. The Storz rod is still very useful. And finally, despite showing us lots of unsettling videos and images of airways, his assertion is that the anaesthetist is the best piece of kit for a difficult airway, and surgeons just need a good view of the airway and a still child. But he acknowledges that it is all very scary.

The final speaker for the session was Dr Joe Unsworth, consultant clinical immunologist at North Bristol Trust. He reviewed NAP 6, which found an incidence of anaphylaxis of 1 in 10,000 GAs, with the majority due to antibiotics (47%), neuromuscular blockers (35%) or chlorhexidine (9%), and a survival rate of 96%. Unlikely triggers were propofol, ondansetron and NSAIDs, with 1 case each per year, and local anaesthetics, opioids and latex, with no cases in NAP 6. Only 34% cases had a tryptase sent. The detail is important when you refer to the allergy clinic, especially drug timings, and a copy of the anaesthetic chart. Dr Unsworth reviewed propofol and food allergy, and although several cases of bronchospasm with or without a rash in patients with egg allergy have been published, none of the patients underwent any allergy testing. A review by Harper in the BJA in 2015 concluded that there was no evidence linking propofol and food allergies in adults, but caution is advised in children.

After the coffee break, session 6 resumed with Kitemarking Anaesthesia, chaired by Dr Nigel Hollister from NDDH. Dr Jon Chambers, consultant anaesthetist at Dorset Hospital spoke from his experience of being part of the process when his hospital underwent accreditation 18 months ago, and from his experience as an ACSA reviewer. Currently the ACSA process runs at a loss for the RCoA. It is a voluntary, peer reviewed QI process. There are 147 standards, of which 138 are priority and must be reached to achieve accreditation. Within the SW, Derriford and Torbay have ACSA accreditation. The standards are based on GPAS and mapped against the CQC, and are reviewed, and therefore change, annually. Department agreement is essential, and the self-assessment is probably the most useful to the department. If your department has ACSA accreditation the CQC often has a light touch approach. After ACSA accreditation, evidence must be produced annually, with another visit needed after 4 years. The cost is about £2685 pa per 50 consultants. The positives from the process in his department were that members of the department and hospital shared a common purpose, it shone a light on areas of "old" practice, it acted as a lever to develop services, and raised

the department profile locally.

Dr Nick Preston, from North Bristol Trust, then spoke about the ACSA experience in his Trust. Following the merger of Southmead and Frenchay, being placed in financial special measures, and being awarded mediocre for surgery by the CQC, there was an impetus to engage with ACSA as a driver for improvement. There was widespread engagement with the process from the Chief Executive and Medical Director, through to the trainees and porters. Policies were rewritten, work was delegated. Some standards were easy to achieve, some needed lateral thinking. Nick was gutted when they failed on 9 standards, but they are nearly there. The positives outweigh the negatives, and the ACSA process has brought 2 hospitals together, improved safety and improved the patient experience.

After the lunch break, with another opportunity to peruse the trade stands and trainee poster presentations, Dr Mike Kinsella, SASWR president, announced the winners of the poster prize. First place was awarded to K Cruse, A Briggs and S Robinson for the poster, “Implementing an infographic project in an intensive care unit”. Second prize was awarded to J Self and M Eveleigh for the poster, “Ditching our desflurane addiction to reduce the environmental impact of anaesthesia –changing practice with minimal intervention”.

Dr Kinsella then chaired the 7th session, Case Discussions. Trainees from the region presented interesting cases. Dr Alec Beaney from Exeter presented “The Management of Major Haemorrhage”. He presented 3 cases that occurred at the RD&E in quick succession. He then presented the results of a survey within the anaesthetic department, which showed that most people encounter major haemorrhage infrequently, and are not confident in the use of cell salvage, the Belmont rapid infusor or the Rotem. Dr Craig Holdstock, from Derriford presented a case of a patient who developed a gas embolism from an unclamped vascath during dialysis. This is an NHS indication for hyperbaric oxygen. The patient received 14 hours of treatment over 4 days, spent 8 days in ITU and 47 days in hospital, but made a good recovery. Craig discussed the challenges of anaesthesia in a remote location, transfers, and compatible equipment (lithium batteries are a fire risk in the hyperbaric chamber). Dr Ed Gerrans and Dr Aisling Brown, CTs from NDDH presented a case of thunderclap headache. A previously fit 22 year old presented with sudden onset severe headache, vision loss, ataxia and seizures, with hypertension. MRI revealed posterior reversible encephalopathy syndrome. Dr Michael Ruiz, from NDDH asked, “do you REALLY want to do this appendix?” An 8 year old presented with chest and abdominal pain, and SOB. Appendicitis was diagnosed, but his heart rate went from 80 to 220 before he reached theatre. The possibility of simultaneous medical and surgical pathologies was raised, but the

decision to treat in NDDH was made, due to the risk of decompensating during transfer to Bristol. His heart rate did not respond to saline, valsalva or adenosine. After discussion with BCH, he was anaesthetised, cardioverted and operated on. His appendix was normal, but he had a mid jejunal intussusception. After a bowel resection he was transferred to Bristol. Dr Shun Yamanaka from NDDH presented the final case of a patient fire. During surgery for varicose veins, smoke was seen arising from the surgical field. When the drapes were removed, an inco pad was found to be on fire. The pad had been soaked in chlorhexidine and alcohol when the skin was prepped, and a RCA found that insufficient time had been allowed for the prep to dry (recommended 3 minutes). The fire was put out with a CO2 extinguisher – do you know where yours is? In 2012 there was an NPSA alert, as there had been 23 cases of fire due to surgical prep. It is commoner in the US than the UK.

Dr David Beard from NDDH chaired the final session of the meeting, Going Global. Dr Rob Conway, consultant anaesthetist at NDDH, spoke about his former life as a guide for Blue Ventures Charity. In 2015 he was a skidoo guide in Greenland, where tourism is the main source of income. The risks posed by an avalanche include asphyxia, trauma and hypothermia. After being caught in an avalanche, he had to walk for 10 hours through waist deep snow. The total evacuation time was 72 hours, meaning that even the most minor injury could become serious. On another trip he escorted tourists to Antarctica, the coldest, windiest, highest and driest continent. The plane landed on a blue ice runway, and everything that is taken onto the ice has to be removed (equipment, food, poo…). The most memorable tourist was an 83 year old lady who was the first person to reach the South Pole backwards on a skidoo. But she lived to tell the tale.

The final speaker was Mr Kevin Carr, a motivation speaker from Ilfracombe, who broke the record for running around the world. He took 600 days, and started and finished on Dartmoor. This is the equivalent of at least 1 marathon per day. His adventures began 11 years ago, when he ran the perimeter of Devon (299.67 miles) after 1 year of training. One year later he ran from Land's End to John O'Groats. He was the first to do this carrying all his own stuff and sleeping wild. He carried just half a sleeping bag and 1/6 of a tent to reduce the weight while affording some protection. Due to confusing joules and calories when he stocked up on supplies near the end of the run, he lost 1 stone in weight during the first 5 weeks, and 1 stone during the last 8 days. To prepare for this run he had built a team of physiotherapist, rugby coach and long distance runner, with over 100 years of experience. Afterwards he didn't run for a year. Then, aged 35, he decided to run around the world. It took 18 months to raise the sponsorship, and cost £15/day. He started on Haytor, and ran 16300 miles, 32,790,600 steps, using 16 pairs of shoes – 1 pair per 1700 miles. He beat the existing world record by 15 hours, but was the first to

run it solo – no support vehicles, just pushing everything in a buggy. The temperatures ranged from -31 to +54. He learned some valuable lessons – you need to drink less milk than water, and it's easier on your stomach than food. Beware of camping in the snow- the tent poles might snap and you would suffocate. So, after a 32 mile run, Kevin set his alarm for every hour during the night, to check the tent, and clear the snow, after which he had to do exercises to warm up before getting back into the tent (but not enough to sweat and get wet and therefore cold). Running across the desert in Australia, with infrequent places to buy water was a challenge between carrying enough water to reach the next pit stop, but not carrying too much, so that he ran too slowly, and needed more water, which would make him run even slower, and need even more water, and so on. The solution was to sleep during the day and to run at night, and to collect his urine in a bottle and spray himself with it (3l/day), to reduce the amount of water needed to produce sweat. It turns out that urine evaporates, but the smell lingers. Even he was retching from the smell. Canada was the most remote place he ran through, with 200 miles between shops and houses. He encountered 26 black bears in 5 weeks, with only pepper spray and shouting to scare them off. He took several photos of bears, when he thought he would be eaten, so the rangers would be able to identify the man-eaters. South America was physically hard as he ran from sea level to 2.5 miles above sea level and back again. In India a car hit him, causing injuries to his buggy and confidence. Kevin felt lonelier when he was running in towns than when he was in the wild. This was especially so in Scandinavia, with his homeless appearance, when people actively avoided him, or looked at him with fear or hostility. To deal with this he tried to separate his feelings from himself, similar to a nerve block. It took about a year to readjust after he had completed the run. Although the record has since been broken, he remains the only person to do it unsupported. Currently Kevin is aiming to qualify for the marathon in the next Olympics, but needs to lose more weight. His tips for success when facing a huge challenge are to break each section into manageable and imaginable stages, and to acknowledge your negative feelings but don't hold onto them.

And that brought another successful SASWR meeting to a close. Many thanks to Guy and the rest of the organising committee at NDDH.

Breakfast is the most important meal of the day

View from Spring Meeting

Judging al fresco

Bursary News

The SASWR Travelling Bursary

Open to trainees and other non-consultant doctors from December

Kick-started by an anonymous consultant member of SASWR who gave a sum of money to be used 'to support trainees', the SASWR committee have decided to provide ongoing annual finance for a travelling bursary to support members of the society to travel overseas to work for the benefit of others in a voluntary or low-paid capacity.

Up to £1000 a year will be made available and will usually go to one individual (in exceptional circumstances the bursary may be split). All trainees and non-consultant grade anaesthetists who are members of SASWR are eligible to apply. (Anaesthetists employed in the South West region may join SASWR in order to make themselves eligible).

Applications (to the Honorary Secretary via email) must be received by May 1st each year. The application should be around 300 words and should outline the nature of the work to be undertaken, and details of any other funding sources;

A decision will then be made by the Hon Sec in consultation with other committee members and the award made over the summer – and announced at the following autumn meeting. We will try and make the funds available as soon as they are needed, once a decision has been made. The recipient will be expected to write an article for Anaesthesia Points West about their experiences on their return.

That's all the boring stuff. This is great news for members of SASWR and we are really grateful to the anonymous benefactor (only they and I know who they are!) who has inaugurated this bursary and enthused us to support it in years to come. Please tell your colleagues about it. We look forward to a flood of applications after the autumn meeting in Bath, where the bursary will be formally announced.

Ed Morris
Honorary Treasurer SASWR

2019 SASWR Travelling Bursary Winner

We are very pleased to report that Dr Abby Harper was the successful applicant for the 2019 SASWR Travelling Bursary.

Abby is spending 3 months working as an Anaesthesia Fellow in BKL Walawalkar Hospital, India. This RCoA-approved partnership involves clinical anaesthesia, teaching of staff and medical students and quality improvement work. BKL Walawalkar is a 500-bed government funded hospital

in rural Maharashtra covering a mix of general surgery, ENT, oncology surgery, trauma, Paediatrics, ITU and obstetrics.

Following this, she is off to Nepal with the International Porter Protection Group. She will be providing medical cover at remote outposts at 4500 and 4800m in the Gokyo Valley for the pre-monsoon season 2020. The post caters to local sherpa populations, as well as passing porters and trekkers. The majority of the work will be managing altitude illness as well as other general medical conditions in a remote environment. She is also hoping to climb as many surrounding 6000+m peaks as possible!

Good luck Abby and we look forward to reading all about it in Anaesthesia Points West!

Implementing an Infographic project in an Intensive Care Unit

K. Cruse, Senior House Officer
A. Briggs, Senior Registrar
S. M. Robinson, Consultant
Intensive Care, Southmead Hospital, Bristol

The new Southmead Hospital opened in May 2014 on the site of the old hospital after the Southmead/Frenchay merger. In order to make navigating the hospital a less daunting task, the building was designed based on an airport gate system. When we first moved into our new unit it was huge with poor signage. It had large grey walls and everything looked the same. The only identifier was a location code - Gate 37, Level 2.

The critical care environment, full of beeps, alarms and machines can be threatening and overwhelming for relatives. This can further intensify what is already a stressful situation. In order to make the unit more visually appealing Dr Stephen Robinson (ICU Consultant), along with Adrian Barclay (from MARLES + BARCLAY) designed infographics to be displayed on the walls. The aim was to provide families and visitors with a better understanding of treatments by depicting a cartoon style patient with all the monitors, pipes, tubes and infusions that could be attached to them. The infographic uses simple, iconic illustrations and descriptions of machine function in straightforward inclusive language – presenting the information in a way that is clear and easily understandable.

In order to understand how visitors had received the new infographics, we devised a short survey that encouraged open answers to five different questions. These questions asked if visitors had found the infographics useful, whether they helped in understanding the function and purpose of the equipment, and whether or not the respondents had any suggestions as to how to further improve or add to the unit.

All of the responses were overwhelmingly positive. One relative described that after seeing the posters they now *'feel less out of your depth surrounded by all the machines - know more about why it's all there*.' A patient's wife told us that the posters had helped her to explain what was happening to her children - '*My kids and I spent time in front of the posters and we spoke about the different machines and how they were helping their father. They loved the posters!*' Some of the suggestions for how we could improve on what we had done included adding posters to the waiting room, putting

more posters up in the corridors, and to consider creating leaflets that could be taken away to study.

As anyone who works in healthcare is aware, nursing staff are the mainstay of any unit. We asked our ICU nurses what they liked about the posters, whether relatives had mentioned the posters and if so, what they had said. We also asked how they felt the posters might be able to help visitors. Of the 48 people who responded to the survey, 100% reported that they liked the posters. The feedback in general was extremely supportive. One nurse responded that they thought that the posters '*can give them (relatives) an idea of what's going on with their loved ones'*, whilst another said that '*I think they (the infographics) make the ICU feel more accessible to visitors and help de-mystify some of the things going on.*'

Our aim for this project was to welcome, orientate, inform and engage. The overwhelmingly positive feedback that we have received from both visitors and our colleagues is proof that we have succeeded in the above goals. People feel more comfortable asking questions, and, we are doing our best to begin to demystify the ICU experience. The unit is colourful, clearly signposted and it is not infrequent to see visitors pausing at the posters as they navigate the corridors. Our next goal is to use the ideas that were submitted to us in the feedback process to further improve upon what we have started – To create an intensive care unit that is cheerful, welcoming, and helps to make visitors feel less overwhelmed.

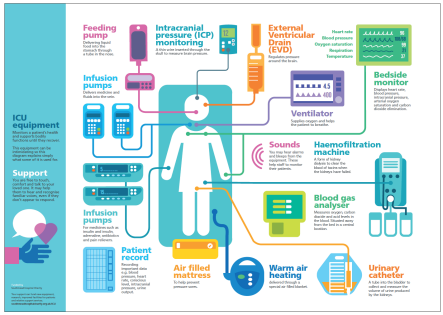


Figure 1: Intensive Care Equipment Graphic

Ditching our desflurane addiction to reduce the environmental impact of anaesthesia – changing practice with minimal intervention

J. Self, ST7 Anaesthetics Trainee
M. Eveleigh, ST5 Anaesthetics Trainee
Gloucestershire Hospitals NHS Foundation Trust

Despite its widely publicised damaging environmental impact, together with its expense, desflurane continues to be very popular in UK anaesthesia. At Gloucestershire Hospitals NHS Foundation Trust, desflurane use was greater than any other trust in the South West region of England in 2017. This work aimed to change practice at the trust to reduce desflurane use, leading to environmental and financial benefits.

A presentation was given to the anaesthetic department, highlighting the environmental impact of desflurane. This was followed by an email summarising the points raised in the talk, and further emails with usage reports.

Desflurane use fell by 75% in the 10-month period following the intervention compared with the same time period in the preceding year (see figure 1), with an average monthly reduction of 20299 ml ($p<0.001$). This equated to a reduction in carbon dioxide equivalents produced from all inhalational anaesthetic agents of 906 tonnes a year and a financial saving of over £70,000 a year. A very simple intervention therefore had a profound effect in practice.

It appears anaesthetists will make changes based on the environmental impact of their practice, but it was evident that the damaging global warming effect of desflurane had not been previously fully appreciated at the trust. It is likely that similar results could be achieved at other hospitals if the environmental impact of desflurane, rather than just its expense, is emphasised. Barriers to reducing desflurane use include fear of change, habit and possibly an over inflated view of its clinical benefits.

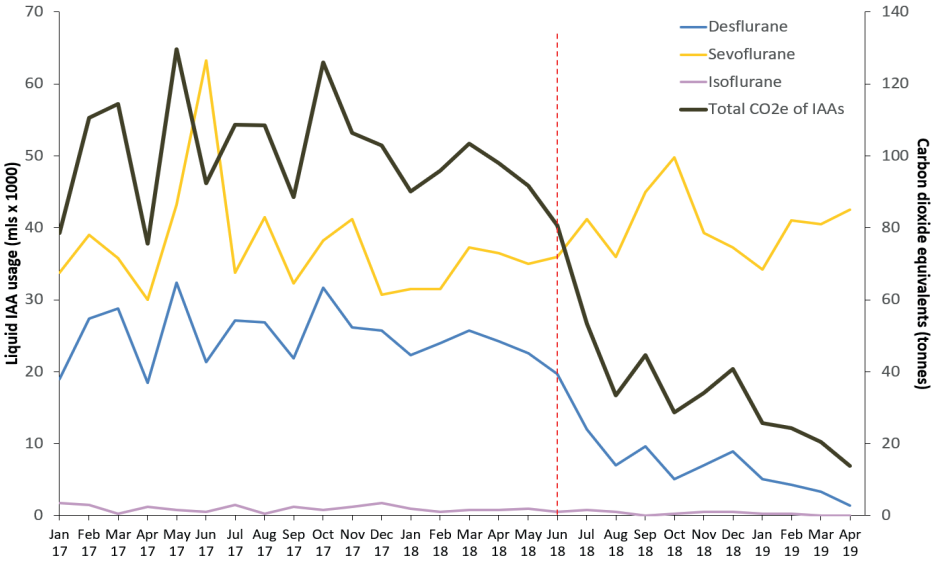


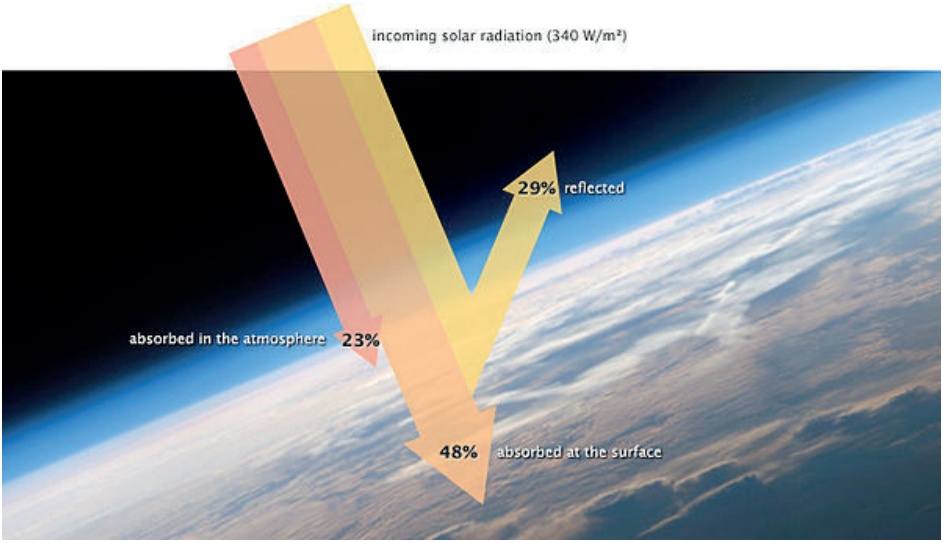
Figure 1 *IAA usage and CO_2e production from IAAs per month, showing a substantial reduction in desflurane use and CO_2e production following presentation in June 2018.*

Anaesthetics and Climate Change

Dr P Valentine, ST7 Anaesthetics Trainee
Dr C Swarbrick, ST5 Anaesthetics Trainee
Royal Devon and Exeter NHS Foundation Trust

As the dramatic effects of climate change become ever clearer we must all do what we can to reduce our own individual carbon footprints. Many of us will have embraced more responsible lifestyles; recycling, cycling to work and turning off appliances...but you may not realise the opportunities we, as anaesthetists, have to reduce our carbon footprints at work too! The potential is massive.

Inhalation anaesthetics, such as nitrous oxide, isoflurane, desflurane, and sevoflurane are all greenhouse gases and contribute to climate change. These medical gases account for 5% of the carbon dioxide equivalence emissions of acute NHS hospitals[1]. 5% may not sound like a huge number but as the NHS carbon footprint represents around 22.8 million tonnes of CO2 equivalents per year, that 5% is significant!



So what does that mean?

A CO2 equivalent (CO2e) is the concentration of CO2 that would cause the same level of radiative forcing as a given type and concentration of greenhouse gas. Examples of such greenhouse gases are methane, perfluorocarbons, and nitrous oxide.

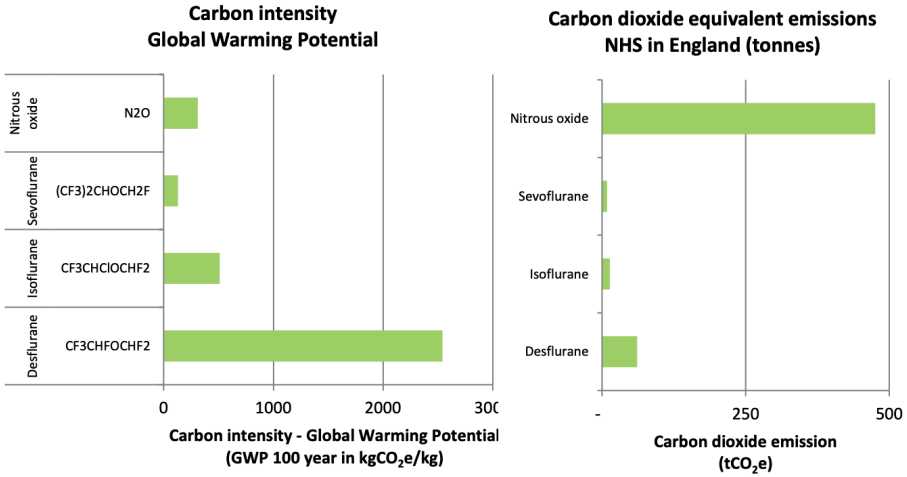
Radiative forcing or **climate forcing** is the difference between insolation (sunlight) absorbed by the Earth and energy radiated back to space[2]. The influences that cause changes to the Earth's climate system altering Earth's radiative equilibrium, forcing temperatures to rise or fall, are called climate forcings[3]. Positive radiative forcing means Earth receives more incoming energy from sunlight than it radiates to space. This net gain of energy will cause warming.

Global warming potential (GWP) is a measure of how much heat a greenhouse gas traps in the atmosphere up to a specific time horizon, relative to carbon dioxide. It compares the amount of heat trapped by a certain mass of the gas in question to the amount of heat trapped by a similar mass of carbon dioxide and is expressed as a factor of carbon dioxide (whose GWP is standardized to 1). A GWP is calculated over a specific time horizon, commonly 20, 100, or 500 years.

What are is the GWP of Inhalational Anaesthetic Agents (IAA)?

Volatile Agent	Sevoflurane	Isoflurane	Desflurane	Nitrous Oxide
GWP 100 (KgCO2e/Kg)	130	510	2540	310

Desflurane has by far the most significant GWP with a GWP100 of 2540 KgCO2e/Kg. However, because of the sheer volume of Nitrous Oxide that is used in the NHS, it remains by far the most significant contribution emissions. In fact, Nitrous Oxide is estimated to account for 99% of the climate impact potential of all Anaesthetic gases[4]. This is illustrated clearly by the following graphs reproduced from the Sustainable Development Unit[1].



Graph reproduced from Sustainable Development Unit[1].

Putting that in to a daily context:

Volatile Agent	Isoflurane	Sevoflurane	Desflurane
CO2e of a vaporised bottle of the agent	190Kg per 250 ml	49Kg per 250ml	886Kg per 240ml

What can we do about it?

The Royal College of Anaesthetists has committed to sustainability through the Charity Governance Code, their Strategic Plan and a joint statement with the Association of Anaesthetists. Furthermore, as of this year, they have developed a Sustainability Strategy[5], which outlines 3 broad areas in which it will target sustainability.

1. The College will aim to minimise the environmental impact of its work as an organisation and move towards achieving the ISO 14001 standard[6].

2. The College will commit to encouraging its members to consider the environmental impact of their clinical practice without compromising

patient safety or quality of care.

3. The College will review its investments to ensure they are consistent with our aim to be a socially and environmentally responsible organisation.

Considering point 2 of the RCOA strategy; on an individual level the easiest way to reduce your carbon footprint at work will be to reduce or even stop using Nitrous Oxide at work.

Using low flows will also significantly reduce the amount of volatile used and where possible procurement of volatile reclamation technology will allow reuse of volatiles – holding to the mantra of reduce, reuse and recycle.

What about Propofol?

Where clinically appropriate, the use of Propofol or TIVA carries a significantly reduced carbon footprint when compared to Volatile anaesthesia. As stated in a paper published in Anaesthesia and Analgesia:

"GHG impacts of Propofol are comparatively quite small, nearly 4 orders of magnitude lower than those of desflurane or N_2O. Unlike the inhaled drugs, the GHG impacts of Propofol primarily stem from the energy needed to operate the syringe pump and not from environmental releases of the drug. Transportation impacts are also negligible, as are emissions from waste management of accessory materials."[7]

To expand, that means that all things considered from plastic use, transport and delivery -TIVA offers anaesthesia with a GWP of 10,000 x LESS than an anaesthetic with Desflurane[8].

With only TIVA only accounting 8% of all UK anaesthetics at present it seems fair to assume there is room for expansion of this technique and a significant reduction in carbon footprint.

Summary

- 5% of the carbon footprint of acute NHS organisations is from anaesthetic gases.
- Nitrous Oxide and Desflurane are the most contributory.
- Propofol has 10,000 x LESS global warming potential than Desflurane.

THINK GREEN!
Use Low Flow Anaesthesia
Minimise Nitrous use
Minimise Desflurane use
Consider TIVA

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The RD&E's Green Team Experience: Reducing Nitrous Oxide Use

Dr C Swarbrick, ST5 Anaesthetics Trainee
Dr P Valentine, ST7 Anaesthetics Trainee
Dr P Ford, Consultant Anaesthetist
Royal Devon and Exeter NHS Foundation Trust

As an anaesthetic department in the Royal Devon and Exeter Hospital, we were approached by Centre for Sustainable Healthcare to enter the 'Green Team' competition. They use a Quality Improvement model to mentor teams from the initial development of 'green project' ideas through to implementation and measurement of their environmental and financial impact. We try to reduce our carbon footprint in our personal and professional lives so we were delighted to be involved.

We attended a workshop facilitated by the Centre for Sustainable Health where we considered the area where we could make the most impact within anaesthesia. We discussed the merits of increased recycling, reusable theatre hats and anaesthetic gases. The clear potential benefit in reducing nitrous oxide use was too great for us to choose any other project. After some mind mapping we decided on a team name of 'Blue Gas Thinking' and allocated roles.

Our first challenge was to find a way of monitoring the amount of nitrous oxide that our trust uses. We liaised with pharmacy who were incredibly helpful and positive about our plans. They reported that we used 315 000L of nitrous oxide with an additional 3 592 800L of entonox per year. After some calculations, we discovered that the nitrous oxide alone was equivalent to 185 kgCO2e or 770 flights to Paris and back!

Our Action

Next, we focussed on spreading the word about the negative environmental impact of nitrous oxide, we used motivational stickers, 'coffee room talk' and enthusiastic email discussions to spread the word. We focused on suggesting alternatives to nitrous oxide and using facts to empower anaesthetists to reduce nitrous oxide use. This gave us the support of our clinical director and management team within theatres.

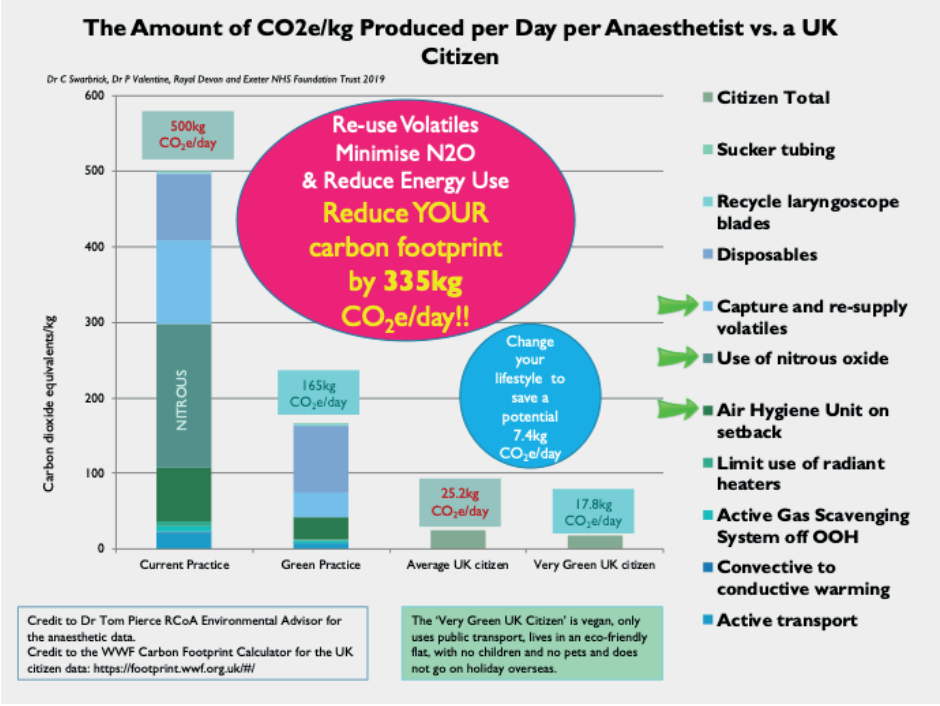
Our initial plan was to take inspiration from recently built hospitals such as Southmead Hospital and remove piped nitrous oxide from main theatres (leaving piped supply in maternity theatres only). The plan was to leave a cylinder of nitrous oxide available on a case by case basis. However, with further departmental discussion we soon realised that the eagerly awaited new anaesthetic machines at RD&E would no longer support an extra cylinder. It was a good example of how

important effective communication is when attempting to instigate change in a department.

The 'Blue Gas Thinking' teams next move was to take part in a departmental debate with Dr Ford pitched against Dr Broomby. There were convincing environmental arguments from Dr Ford against enthusiastic pro-choice arguments from Dr Broomby. There was a vote that fell in preference for the pro-choice movement, so our plan to remove nitrous oxide from theatre was thwarted. At the risk of sounding like a 'remainer' discussing a second Brexit referendum, the vote *was* held on the same day as the Summer SASWR meeting so voting numbers were low...!

Ongoing Efforts

Despite these setbacks, we have managed to reduce our nitrous oxide use within theatres. We have noted a reduction of around 22 500L from May-June 2019 compared to the same months in 2018. This continues to fall. The Green Team Competition is now closed awaiting the judging! The 'Blue Gas Thinking' team haven't given up our goal of reducing and eventually removing nitrous oxide from theatres. We have been working with the Environmental Advisor for the Royal College of Anaesthetists, Dr Tom Pierce to produce convincing and relevant posters. Please consider the facts on this poster below:



Removing nitrous oxide from your anaesthetic practice is the single most effective positive environmental change you can make within your personal and work life. We hope that by promoting the use of alternative techniques to nitrous oxide use and emphasizing the huge difference individual anaesthetists can make, we can gradually phase out nitrous oxide from anaesthetic practice. We hope that this article makes you consider your own nitrous oxide usage. Please look through the table at the end of the article to see how you can make your practice more sustainable.

Anaesthetic	Traditional Management	Simple Swap	Background
Paediatric gas induction	Gas induction: Nitrous oxide, oxygen, sevoflurane	Gas induction: Oxygen, sevoflurane	182 patients studied in Pakistan for differences between gas inductions with and without nitrous. No significant difference in induction timings or adverse events[1]
Short stimulating procedure, little pain afterwards	Nitrous oxide maintenance	Remifentanil TCI or alfentanil	70 orthopaedic patients in New York studied for difference between addition of nitrous for remi for analgesia. Patients receiving remi had less time to reorientation, no difference between time to awakening[2]
Elderly patients with multiple comorbidities	Nitrous oxide maintenance	Use of BIS to carefully titrate anaesthetic	

Drs Pete Valentine, Claire Swarbrick and Fiona Martin, part of Exeter's 'Green Team'

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The Hyperbaric Physician

Dr Craig Holdstock, ST6 Anaesthetics Trainee, Plymouth Hospitals NHS Trust, and Hyperbaric Physician, DDRC Healthcare

Outside of my role as an Anaesthetic Specialist Trainee currently undertaking an Advanced Fellowship in Cardiothoracics and Imaging, I am a Hyperbaric Physician. Having this extra role contributes to my continuous professional development both medically and non-medically.

DDRC Healthcare is based at Plymouth Science Park in Plymouth and is a worldwide specialist in diving medicine, hyperbaric oxygen therapy and medical training. It employs approximately 60 staff as regular employees and contracted bank staff with an annual turnover in the region of £2 million per year. DDRC Healthcare delivers a 24/7 diving and hyperbaric medical emergency service. It is a not-for-profit organisation and a registered UK charity. It is registered with the Care Quality Commission and works closely with the NHS and emergency services.

My journey into hyperbaric and diving medicine began whilst studying at Peninsula College of Medicine and Dentistry. As a keen scuba diver I applied and was successful in obtaining a position on the bank staff at DDRC as a Chamber Attendant.

The Chamber Attendant's role is to look after patients receiving both emergency and elective hyperbaric oxygen therapy. When patients receive hyperbaric oxygen therapy they are compressed in a chamber where they breathe oxygen, with occasional air breaks, at increased pressure depending on the treatment table used. The Chamber Attendant goes into the chamber and supports the hyperbaric treatment. Here they assist the patients, monitor for any untoward events and provide basic care to the patients, whilst providing a direct link between the patients and staff outside the chamber. This initial exposure was excellent in obtaining patient exposure and care whilst an undergraduate.

Towards the end of Foundation Year 2 I completed the Level I Medical Examiner of Divers. During my Anaesthetic Core Training I completed the Level IIa Medical Management of Diving Accidents/Illnesses. These courses are internationally recognised to have the necessary knowledge to become a Hyperbaric Physician. Over a number of months, I was on-call with a senior hyperbaric physician. I continued to develop my knowledge and experience before I was assessed as being competent to become a Hyperbaric Physician at DDRC.

Since 2013 I have been a Hyperbaric Physician at DDRC whilst continuing in my normal work as an Anaesthetic Trainee. I undertake this work by providing predominantly out-of-hours on-call shifts outside of my normal

clinical commitments. There is complete flexibility in the amount of support that I offer to DDRC dependent on my other commitments.

The on-call Hyperbaric Physician provides emergency hyperbaric and diving medicine advice 24/7 through either direct contact to DDRC or via the British Hyperbaric Association (BHA) helpline. Anyone is able to call this number including patients, divers, emergency services and clinicians. This number provides both national and international emergency hyperbaric and diving medicine advice. Currently the NHS commissions the treatment of Decompression Illness and Vascular Gas Embolism.

Calls are usually routed via a call handling service where you receive contact details for the individual contacting the emergency number. As the on-call Hyperbaric Physician you undertake a telephone consultation and following this undertake a management plan. This includes giving advice, referral for medical assistance, referral to another hyperbaric unit, assessing the patient yourself, or treating the individual with emergency hyperbaric oxygen therapy. This can sometimes involve working with emergency services such as the Coastguard and the Ambulance Service, including complex situations such as talking to dive boats by being routed by the Coastguard through VHF Emergency Channels.

Emergency hyperbaric oxygen therapy is undertaken at DDRC. This involves calling in a team including a dive supervisor, chamber operator, chamber attendant and the presence of a Hyperbaric Physician. Emergency treatments are predominantly carried out in our large multi-place hyperbaric chamber (Figure 1).

More recently I have been involved in the improvement of services delivered at DDRC by ensuring that we have the capability to be a category 1 hyperbaric facility. Category 1 hyperbaric facilities are defined by the BHA as those that should be capable of receiving patients in any diagnostic category who may require Advanced Life Support either immediately or during hyperbaric treatment. Therefore, I have been involved in the upgrade of our facilities to ensure that we have a hyperbaric compatible ventilator, syringe pumps and monitor which has full standard monitoring. This was recently put into practice by myself with the treatment of a patient who had an iatrogenic vascular gas embolism who required intubation and critical care but was safely treated at DDRC Healthcare (Figures 2 and 3).

Figure 1: The multiplace chamber at DDRC.


Figures 2,3: An intubated and ventilated patient in the multiplace at DDRC.

STAR Update

Dr Katie Samuel – STAR executive chair

STAR Group

SEVERN TRAINEE ANAESTHETIC RESEARCH

Collaborative Anaesthesia and Intensive Care Research in the Severn Deanery

It has been a brilliant year for STAR – continued expansion with new committee roles, exciting projects underway and winning a national prize to top it all off!

We were delighted to win the prestigious RCoA and NIHR joint research award, recognising our continued success as a trainee research network and our contribution to NIHR portfolio studies. We were chosen following a nationally competitive application, and along with a financial prize we are looking forward to formally receiving our award at the 2019 Anaesthesia Research conference next month.

Our 2019 STAR annual research congress in June was a great success – held at North Bristol Trust, we heard from an array of national and regional speakers, as well as holding our annual project pitches. Our winning pitch was presented by Swati Gupta on perioperative smoking cessation (planned to start early 2020), with excellent pitches also from Aggie Skorko and Charlie Pope. Many thanks to our national speakers and extended committee for helping choose the winning topic.

In this latter half of 2019, we again are delighted to announce not only new committee members but also two newly formed committee roles. Aravind Ramesh and Helen Williams have taken over the roles of General Secretary and Anaesthesia Vice-chair respectively, with Kate Reeve and Ben Hearne stepping down from their roles; we wish them both all the best for the future. We have also created two new roles to manage our expanding network, with Suzanne Harrogate taking on the new role of Event Lead, and Sethina Watson (previous STAR fellow) taking on Local Lead Liaison. We hope that these roles will help us in delivering high quality STAR events, and strengthen the relationship between the committee and our local leads.

The 'Perioperative Anaemia Management in Severn (PAMS) Project – our cross-site quality improvement (QI) initiative continues to develop. The PAMS project has looked at data relating to anaemia from the four PQIP (Perioperative Quality Improvement Programme) centres within STAR's geographical borders, as well as gathering additional data on local perioperative anaemia testing and treatment protocols. Having

been presented at the RCoA national conference in May, and included as an example of collaborative working in the 2019 national PQIP report, the project is now reviewing results and guidelines to produce QI targets.

We are delighted to introduce our 4th STAR fellow, Tom Clements, based at North Bristol Trust, who started his role in August. He has started his year with a QI project evaluating NBT's elective ICU admissions, along with taking over as NBT trainee lead for the FLOELA trial. Tom also plans to undertake research using the regional trauma database over the next few months.

Our STAR website (www.anaesthesiaresearch.org) secure 'members' area' for trainees continues to develop, with local STAR leads adding details of local research and QI projects – a great resource for trainees starting at a new Trust and looking for projects to get involved with.

We have an active following on Twitter (@STAResearch and @STAR_Research) with over a thousand followers; follow us for research and QI updates as well as the odd comedic tweet. If you would like to join STAR and be involved in great research projects (medical students and foundation doctors are also eligible) just sign up for free via our website.

Have an idea to pitch? Want to get more involved with STAR? Drop us an email at stargroupresearch@gmail.com.

SWARM update

Dr Debbie Webster
SWARM Chair

Rachel Remnant is this year's SWARM fellow. She takes over from Andrew Woodgate and continues to recruit patients to COMPASS (Cognitive Monitoring in Planned Arthroplasty Surgery Study) at Torbay. We continue to be extremely thankful to the hard-working research nursing staff at Derriford for doing the lion's share of recruitment to date. COMPASS is a portfolio adopted feasibility study aiming to use an online tool to map cognitive function in patients undergoing arthroplasty surgery and in matched controls. Matched controls have been successfully recruited by our General Practitioner colleagues. The study aims to recruit 150 patients, we have recruited about 50% of our target so far. Please talk to Rachel Remnant if you would like to help at Torbay or Jo Burrows if you can help at Derriford.

Anna Ratcliffe won the Regional Training Symposium Hive of Ideas in 2017 with her plans for AFAR (Accelerometers for Assessing Recovery). She subsequently secured herself an Academic Clinical Fellowship, teamed up with OpenLab in Newcastle and has now completed recruitment and data collection for the CRN portfolio study. The next phase is data analysis. Anna has made SWARM very proud by winning the Hughes Medal at the BJA research forum in May 2019.

The 2019 Hive of Ideas winning and runner up studies are progressing nicely through the planning stages and will soon be entering data capture stage across the South West. James Womersley's project pitch won the 2019 Hive of Ideas. He will be leading a project to define long term survival following intensive care admission in each trust in the Peninsula region. This will involve retrospective analysis of patient outcomes following ICU admission. The project is currently being submitted via IRAS (Integrated Research Application System) so watch this space. James has lead helper bees in each Trust but if you are keen to help data collect then do contact James or your local lead. Ben Whatley's (very current) runner up project nobly aims to minimise volatile pollution by encouraging us to rethink our flow rates when using volatiles. The project comprises questionnaire and audit based components and has started data collection in Torbay. It will soon to be rolled out to other Trusts. Ben has managed to recruit site project leads in all trusts but Derriford, so please contact him if you would like to help run the study in Plymouth.

2018 Hive of Ideas project will assess the incidence of perceived inappropriate intensive care provision. Increasing evidence links this to workplace stress and burnout so we would like to see how significant

a problem perceived inappropriate organ support is within our intensive care units. We hope to collaborate with STAR to collect data across both Peninsula and Severn. This study questionnaire has been piloted at Taunton and is currently being reviewed by the ethics committee. We hope to start recruitment in the next few months.

In terms of other research activity, SWARM have successfully linked trainees to assist with the Paediatric Anaesthetic Trainee Research Network (PATRN)'s next study PEACHY in Trusts across the South West. PEACHY will investigate the rate of childhood obesity in the paediatric population undergoing general anaesthesia, the rate of perioperative complications, and paracetamol dosing. SWARM will data collect for SQUEEZE, a portfolio adopted, European Society Anaesthesia study exploring the incidence of postoperative vasopressor use, agents used and complication rates. More on this soon.

Date for the diary: Our next Research Training Symposium will be held at Buckfast Abbey Conference Centre 16th March 2020. Get your study leave request in now!

If you have ideas or want to get involved with any of the projects due to start recruitment, please contact your local lead (see below).

Keep SWARMing!
@ukswarm
https://www.ukswarm.com/

Locals leads

Barnstaple – Edit Chase	Taunton – Will Hare
Exeter – Tom Woodward	Torbay – James Womersley
Plymouth – Jo Burrows	Truro – Katharine Sprigge

The Wine Column

By Tom Perris

The Best of British 2018 Vintage

As I write, we are still in the EU, Boris Johnson is still prime minister and we are no nearer resolving the political issues that have stagnated the country and paralysed investment than we were on the day of the referendum. I truly hope that two out of three of these is not the case by the time I next sit at my keyboard on your behalf. Sorry to start in such a depressing frame of mind but I have good news (I promise!). The pound may have fallen harder than an octogenarian on an icy morning and the news may be as predictable as a winter bed crisis but the sun shone all last summer and the UK wine harvest broke all records both for volume and quality.

Since the vast majority of wines drunk in this country are imported, their relative price has risen in inverse proportion to the falling pound and are now more overpriced than ever. Not so in England though. Whilst some things in the British wine industry are usually imported (barrels and bottles being chief amongst these), the bumper harvest (more than double the average in most areas), the increasing scale of production and the greater sales revenue have allowed prices for home-grown wine to be stable or even lower in some instances.

Also, the changing climate has, at least for southern England, improved wine growing conditions and more areas are now suitable for ripening grapes. Add to this the maturing vines, improved siting and planting of appropriate varieties and English wine is now a viable alternative to pretty much any white wine you may care to name. Indeed, the situation of southern England is considered to be sufficiently favourable that the venerable old champagne houses of Tattinger and Pommery have purchased tracts of land in Kent and Sussex. And our sparkling wine is good. This year, English and Welsh wines picked up more awards than Champagne (a first) and an English winemaker won the Sparkling Winemaker of the year award (another first) and she happens to be a woman (yet another first). But it's not just in fizzy wine that the UK excels. The production of still wine is booming too. However, the still relatively cool climate means that we struggle to ripen the varietals planted in warmer parts. Bacchus, a cross of Reisling- Sylvaner and Muller-Thurgau seems to be the grape which thrives best in English conditions and gives a delicious, crisp, cut-grass and elderflower scented wine not dissimilar to some Sauvignon blancs. I was, recently, a guest at Sharpham Estates, conveniently located near Totnes - midway between Torbay and Derriford Hospitals, and they make several

delicious white wines using Bacchus and Madeline Angevine grapes.

We grow a lot of Chardonnay too which may be more familiar to most people. However, most of it is reserved for sparkling production as not all summers will achieve sufficient ripeness for still wine. Some producers, however, are now altering that idea and, using premium fruit from ideally sited vineyards and more mature vines, are making superb quality whites. I recently drank an English Chardonnay from Gusbourne in Kent that was, very nearly, the best white wine I've drunk this year. Bearing in mind I've just turned fifty and had a very special dinner party to mark the occasion, with some very special wines (thanks Ben) that is praise indeed.

Perris's Picks

Most English still wines are not widely distributed unlike the increasingly available sparklers. Thus, your best bet is to look online or visit the vineyard, but I urge you to try them if you can.

Bolney, Lychgate Bacchus 2018. £12.99 (online). A top example of the type of fresh style typified by English Bacchus. Green apples and elderflower.

Sharpham, Dart Valley reserve 2018. Chiefly Madeline Angevine grapes with a varying blend of others for perfume and consistency of style, this is a lovely, crisp white to sip on a warm afternoon or, wash down your posh lunch. £14.00. Available online, at the vineyard or at Totnes Wines (a very good shop- ask for Roger!)

Gusbourne Estate, Guinevere Chardonnay 2014. £25-28. Not cheap but comparable in quality and style to the finest white burgundies. Imagine a premier cru Mersault and you'll not be far off. Truly delicious and stunning in quality. Worth every penny. Available via Berry Bros or online. Gloucestershire residents can get it at Tivoli Wines. They make award winning sparklers too.

Enjoy!

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All articles should be sent by email to the editor (see below for address). Scientific articles should be prepared in accordance with uniform requirements for manuscripts submitted to biomedical journals (British Medical Journal 1994; 308: 39-42) i.e. as used by Anaesthesia. Please ensure that references are complete and correctly punctuated in the required style. The approved abbreviations will be used for journal titles. Photographs should be sent as separate attachments. All articles should be sent as Word documents, and especially not PDFs, Pages documents etc. Please send photos separately and label appropriately. The deadline for submissions is usually 10 weeks before the next meeting of the society.

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