Journal of the Association of Surgeons of Great Britain and Ireland

Number 46, Summer 2015

MESSAGE FROM THE PRESIDENT

It is a great privilege and a pleasure to take on the Presidency of the Association of Surgeons; the first six months seem to have flown by!

I am happy to say that the dust has finally settled after the Mid-Staffordshire scandal, and we are all hoping that lessons have been learned from what has been a very difficult time for patients, their relatives and hospital staff.

While the initial reaction to the Shape of Training Report was a concern that all the benefits of sub-specialisation could be undone, recently a more balanced view has gradually evolved, with many now recognising that the general surgical trainee of today is not that far away from what the Greenaway Report has been advocating. The introduction of change is always a very slow process, so it is likely to be some years before we finally know what the Shape of Training Review will finally produce. My advice to our trainees is "no need to panic".

The importance of Emergency General Surgery is now very much centre-stage, and the credit for this must go to Iain Anderson who recently demitted office as our Director of Emergency Surgery. Iain has managed to raise the profile of this very important part of our work which has often been ignored by many. As a result of his efforts it seems inevitable that big improvements in the delivery of this service will gradually follow. It is the firm view of the Association that Emergency General Surgery should remain core business of the general surgeon with all those gaining a CCT in General Surgery continuing to have a major contribution to its delivery. The joint document produced by ASGBI, ACPGBI and AUGIS is a huge step forward, as it goes some way to describing how the service should be delivered and by whom. If you haven't yet read this important document I would urge you to do so. See '***Joint Document on The future of EGS***' at:

http://asgbi.org.uk/en/publications/issues_in_professional_practice.cfm

NHS politics continues to be a source of angst for all of us. The hot topic at the moment is the concept of the seven-day NHS. All General Surgeons will have reacted to this with some degree of amusement, given that we have all been delivering a seven-day service since we were Junior House Officers. In this regard we have no problem with the seven-day concept, as it is something we have grown up with. Can we deliver elective work at the week-ends as well as the emergency work that we have always done? The simple answer is probably yes, but only if such a service is fully resourced and staffed. This, of course, doesn't just mean medical staff, it also means nurses, ancillary staff, physiotherapists, social workers, management etc. Saturday and Sunday really do have to look like any weekday. Many, quite reasonably, question how such a system can work given the pressures that we are currently under to reduce our working hours to comply with the European Working Time Regulations, particularly when the government is willing to impose fines on Trusts who breach the same regulations. Given therefore that we are being prevented from working longer hours, it seems inevitable that, for a seven-day NHS to work properly, there will have to be an investment in all kinds of staff to deliver this service. If not, all we are likely to see is five days' elective work spread over seven or the likelihood that Wednesday and Thursday could become the new week-end. With surgeons, more than most, being fully aware of what is necessary to deliver a seven-day elective NHS, government statements that the service should be cost-neutral are greeted with some degree of incredulity. Despite this, I think we should be prepared to show a willingness to embrace the seven-day NHS and work with the government to see if it can be delivered. I suspect that most in surgery feel that it cannot, in the absence of significant, increased expenditure, but by showing a willingness to get involved, we cannot be accused of stifling progress. Clearly we will have to wait and see where this goes. I am sure you would all agree that the recent bout of doctor-bashing in the press driven by our political masters is both grossly unfair and counter-productive, particularly when so many doctors spend such a large part of their time working at night and over week-ends. It seems inevitable that this endless onslaught will discourage our current medical students from considering a career in hospital medicine. It may also

deter today's schoolchildren from considering a career in medicine altogether. If we do have a shortage of hospital doctors in the years ahead, I think we will all know who to blame.

Our Annual Congress this year in Manchester was an outstanding success with over 1,500 delegates attending over the three-day period. This Congress also highlighted the real benefits of working with other surgical associations. In addition to having our old friends, the Association of Trauma & Military Surgery, this year we shared the venue with the European and African HepatoPancreato Biliary Association. We had an impressive array of national and international speakers at the Meeting, contributing to a wide range of symposia that were of interest to all types of general surgeons regardless of their specialty interests. It was also a great honour for us to have Her Royal Highness The Princess Royal open the Meeting.

Planning for next year's Surgical Week in Belfast is already well underway. As before, we hope to have a number of 'big' names from around the world contributing to a wide variety of symposia, again providing something of interest to all working under the umbrella of general surgery. The dates for next year's Congress are **Wednesday 11th to Friday 13th May 2016** so put these in your diary now. In addition to what should be a first-class scientific programme, we are also planning an excellent social programme, so I would urge you to come to Belfast next year to what should be a great event.

I hope you all have an enjoyable summer, and I will be in touch with you all quite soon via '**@SGBI**', our President's E-zine.

R J Moorehead, MD, FRCS
President
Association of Surgeons of Great Britain and Ireland

EDITORIAL

Welcome to the summer 2015 issue of ***JASGBI***, the journal of the Association of Surgeons of Great Britain and Ireland, through which we seek to inform and entertain the ASGBI membership on matters of significance and interest in the professional lives of General Surgeons. Astute and insomniac observers will have noted a change to our production schedule this year. We dropped the spring issue of the Journal, which coincided with the substantial corporate effort to make the 2015 Manchester Surgical Week, the success which it proved to be.

We have now introduced **@SGBI**, a monthly President's e-zine, to give us a more frequent and efficient communications tool for information which is time sensitive or which would not be appropriate for the JASGBI. We hope that these changes meet with your approval. Please drop us a line with your thoughts and views, and note that we are always on the lookout for items and articles which may be of interest to the general membership.

Thus far in 2015, the professional waters have been somewhat less turbulent than in 2014. The General Election has diverted political energies and has seemingly pulled the teeth from a number of issues on our Executive Agenda. The Greenaway Report on professional education and early career training is still under review, and little has been heard of it in the professional press in recent months. The excitement over the publication of Surgical Outcomes has abated, and there has been little new to report, all be it that there is an inexorable trend to greater freedom of information flows around the healthcare space. The current 'hot topic' is, of course, the Government's agenda for seven-day working, and the Federation of Surgical Specialty Associations (FSSA) Position Paper on this is now available, under 'publications' at:

www.fssa.org.uk

Your Executive Board continues to scan the horizon for developing issues and emerging themes to debate and publicise. However, we have welcomed the relative political lull to do some housekeeping and strategic thinking to keep the ASGBI relevant and affordable for the membership, and to strengthen the collegiate working between the ASGBI and the various representative Sub-speciality Associations and Societies.

The Executive Board is kept vibrant by renewal its Officers and refreshment of its Posts. We are sorry to note the departure from his role of Iain Anderson, MBE as the first Director of Emergency General Surgery of the ASGBI. EGS is now recognised as a major discipline in its own right, with very important ramifications for the safe and successful delivery of healthcare in the NHS. Iain has made a major contribution to the development and profiling of Emergency Surgery at national level, and will continue to do so.

We are also sorry to note the departure of Gareth Griffiths from his role as the Chairman

of the SAC in General Surgery, and an observer member of the ASGBI Executive Board. Gareth brought a combination of hard work, attention to detail and abundant common sense to this post, and we wish him well in his new intercollegiate role as ICSP Programme Director. We are pleased to welcome Professor Jon Lund to the role as Chairman of the SAC, and look forward to him continuing the important links between the SAC and the Association.

We are also sorry to note the departure of Nick Markham from his most recent role as Director of Informatics. Nick contributed a combination of wise judgement and enthusiasm for the "digitisation" of the Association, notably in the development of the website; of the ASGBI App and of the introduction of the "Paperless Congress" in 2014. We are delighted that Nick has been elected as the Association's representative to the restructured Council of the Royal College of Surgeons of England, in which capacity he will also sit as an observer member of the ASGBI Executive Board and Council.

With a view to further digital transformation, we are in the process of examining and integrating the functions of Communications and Informatics in the Association, and in bringing on board a generation of clinical leaders who can further the programme of social media engagement and optimise our "informatics product".

With the election of Professor Rowan Parks to the vice presidency of the Association, we are delighted to welcome Miss Karen Nugent as our Director of Education to oversee the Educational Portfolio which Rowan did so much to expand. We look forward to Karen's contributions to the work of the Executive Board, founded in her considerable experience of Deanery work and as a recent Past President of ACPBGI. In this context, we are examining a number of initiatives to improve professional representation in partnership with the executive officers of the ACPGBI, AUGIS, BAETS, BHS and the other sub-speciality bodies with whom we meet regularly through the ASGBI Council, and through informal contacts.

We are delighted that the finances of the Association continue to strengthen through robust examination of all of our costs, and through the delivery of a financially successful Congress. We are grateful to Neil Welch for his astute guardianship of the accounts since taking on the role of Director of Finance.

We are also grateful to John Hartley for taking on the challenging role of Director of Professional Practice. He has the remit of refreshing the channels of engagement with the membership and a detailed examination of the roles and effectiveness of the ASGBI Elected Regional Representatives, who for some years have been 'co-roled' with the RSPA posts of the Royal College of Surgeons of England.

We are also grateful for his continued interest in the Association of Professor Lord Ajay Kakkar, who has been a stalwart supporter and advisor to the Association in various roles over many years, most recently in the formal post of Director of External Affairs. It is a tribute to his professional and interpersonal skills that Ajay has been appointed both as a Privy Councillor and as Chairman of the influential House of Lords Appointments Commission.

And so to the highlight of the Association year; the annual International Surgical Congress. This issue contains much about the very successful Manchester Surgical Week in April 2015, which was attended by HRH The Princess Royal and which was run jointly with the E-AHPBA and ATMS. We are most grateful to Professor Gordon Carlson as Director of the Scientific Programme for his sterling work in designing the programme and in pulling it all together. We are also grateful to his colleagues in Manchester for their help, and particularly to Baljit Singh, his Deputy, who is now leading the planning for the 2016 Congress.

This will be held at the new Belfast Waterfront Conference Centre between Wednesday 11th and Friday 13th May 2016. We are particularly pleased to be making this infrequent Congress visit to Northern Ireland, where work is in hand to engage as widely as possible with the professional community across Ireland. The theme for the 2016 Congress is "**Surgery in the Digital Age**", which resonates with national policy to move to a more digitally enabled NHS in this decade.

We once again thank Nick Gair and the office staff of the Association, whose sterling work and loyalty is critical to the success of the Congress and to the daily running of the ASGBI.

Finally, I thank you for your continued support of the Association on behalf of my colleagues on the Executive Board and on behalf of John Moorehead, our President. We do our best to make the Association as relevant as possible to your needs, and all feedback is welcome, through whichever communication channels you choose to use.

David Rew
Director of Communications

Question the norm.
Do the tools you need exist today?

According to us, the answer is no. But each new device takes us closer.

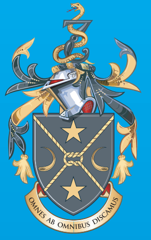
Zenapro, for instance, is the first hybrid hernia-repair device. A sheet of ultra-lightweight polypropylene mesh surrounded by extracellular matrix, Zenapro gives patients a permanent repair while leaving behind minimal foreign material in the body.

Learn more: visit **zenapro.cookmedical.com.**

Zenapro™
Hybrid Hernia Repair Device

www.cookmedical.com

© COOK 06/2015 | SUR-D20578-EN-F



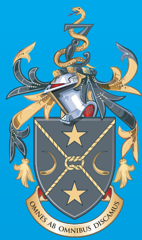
2015 CONGRESS OVERVIEW

From Tuesday 21st to Friday 24th April 2015, the Association of Surgeons of Great Britain and Ireland (ASGBI), the European and African Hepato-Pancreato-Biliary Association (E-AHPBA), and the Association of Trauma & Military Surgery (ATMS) came together for a joint congress under the banner of the **Manchester Surgical Week**.

We were honoured that HRH The Princess Royal opened the Manchester Surgical Week, and spent the best part of a day at the congress, which was held at the Manchester Central conference centre.

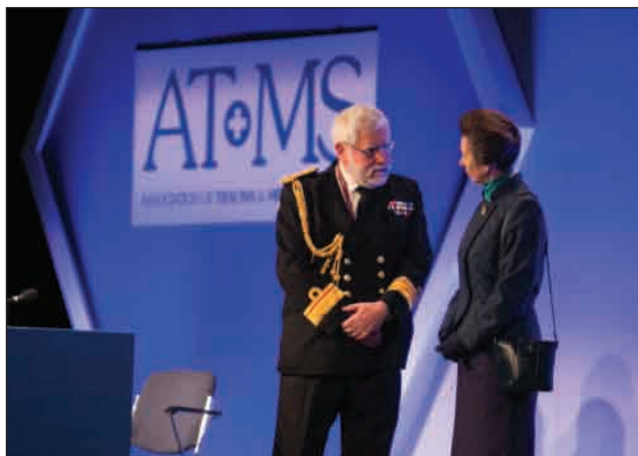
HRH The Princess Royal arrived at Manchester Central to be met by Professor Nicholas Gair (Chief Executive, ASGBI), Surgeon Captain Professor Mark Midwinter, CBE (President, ATMS), Professor Ajith Siriwardena (E-AHPBA Congress President) and Mr John Moorehead (President, ASGBI).

Professor Claudio Bassi, President E-AHPBA, Professor Martin Smith, President-Elect E-AHPBA, and other E-AHPBA Council members chatted with Mrs Sharman Birtles, The High Sheriff of Greater Manchester, and Councillor Susan Cooley, The Lord Mayor of Manchester.



During HRH's time at the congress, she met many of the Presidents of the wide range of Surgical Colleges and Specialty Associations and a number of the distinguished speakers – from the UK and Ireland and around the world - who were contributing to the event. The Princess also spent some time in discussion with the International Bursary Winners.

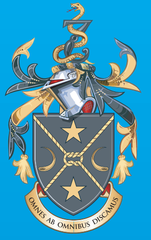
The Surgical Foundation 2015 International Bursary winners (from left to right) were Dr Emmanuel Lema from Tanzania, Dr Margaret Wassawa from Uganda, and Dr Charles Mabedi from Malawi. The Surgical Foundation is extremely grateful to The Royal College of Physicians and Surgeons of Glasgow, the BJS Society, Senior Fellows and Mr Jonathan Pye for their generous support of these bursaries.



HRH specifically requested to attend the ATMS Military Surgery Congress and listen to the annual Guthrie Lecture. Greeted to the platform by Surgeon Rear Admiral Alasdair Walker, OBE, HRH graciously consented to present the speakers' medal to Mr Michael Crumplin, the 2015 Guthrie lecturer.

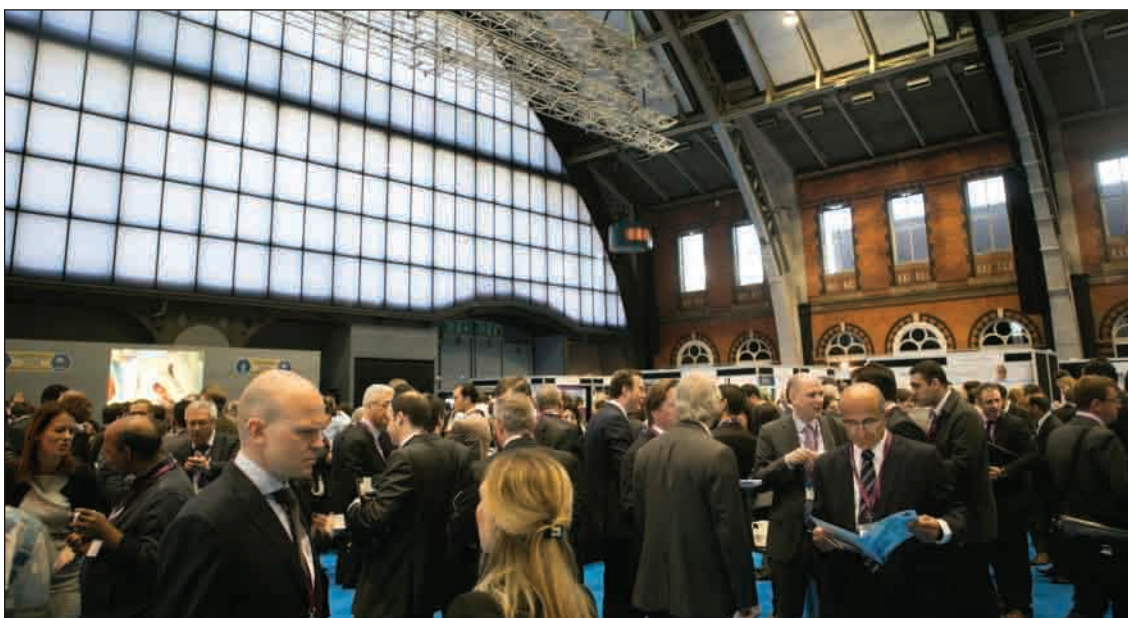
With around 1,600 medically qualified delegates attending the combined event, and a total of over 1,250 scientific abstracts being submitted for marking, this was, arguably, the largest and most successful ASGBI Congress ever, offering a stimulating joint programme of scientific, educational, professional and clinical interest.

Dr Gerard Panting, from SIS (the ASGBI's own surgical indemnity scheme) delivered "A brief yet disturbing history of medical manslaughter" as part of a symposium on 'Surgeons and the Law'.

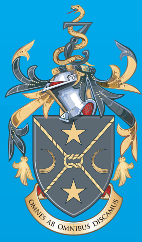


Professor Raymond Tallis gave the ASGBI Guest Lecture on Thursday 23rd April entitled 'The Destruction of the NHS'.

The combined Congress Registration Desk was kept busy for the three days.



As usual, the Congress featured a bustling Industry Exhibition.



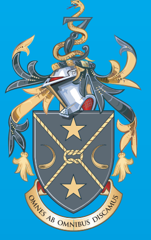
Manchester provided a splendid backdrop to the combined congress social events, and all three societies – ASGBI, E-AHPBA and ATMS – took the opportunity to host some most enjoyable dinners.

Lieutenant Colonel Doug Bowley (Vice President, ATMS) took command of the quiz at the Annual Military Dinner, held at Old Trafford Football Ground.

The Association's 2015 Council Dinner was held in the magnificent setting of Manchester Town Hall.

All the photographs from the 2015 **Manchester Surgical Week** are available to view at:

http://www.asgbi.org/manchester2015/



2015 HONORARY FELLOWS OF THE ASSOCIATION OF SURGEONS OF GREAT BRITAIN AND IRELAND

ASGBI awarded four Honorary Fellowships at the 2015 International Surgical Congress, which were presented at the Council Dinner in Manchester Town Hall on Tuesday 21st April. The following distinguished surgeons were all extremely worthy recipients of the Association's highest honour.

Dr Andrew L Warshaw

Dr Warshaw, the 95th President of the American College of Surgeons, is a graduate of Harvard College and of Harvard Medical School. He is the W Gerald Austen Distinguished Professor of Surgery and Surgeon-in-Chief Emeritus of the Massachusetts General Hospital. Dr Warshaw has been President of many professional organisations. He was a Director of the American Board of Surgery and its Chairman in 1993. He conceived the volunteerism programme of the American College of Surgeons, Operation Giving Back. In 2007, Andrew was appointed Chair of its Health Policy and Advocacy Group. He has made contributions to the understanding of inflammatory and malignant lesions of the pancreas. His bibliography lists more than 425 original reports as well as 240 book chapters, reviews, and 13 books. He is Editor-in-Chief of Surgery. Andrew has received the Master Educator Award of the Society for Surgery of the Alimentary Tract, the Lifetime Achievement Award of the American Pancreatic Association, the Founder's Medal of the Society for Surgery of the Alimentary Tract, and the James Ewing Medal of the Society of Surgical Oncology.

Professor Claudio Bassi

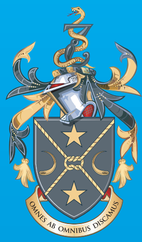
Claudio Bassi was born in Verona, and qualified in Medicine (MD) at the University of Padua, and obtained his certification in General Surgery in from the University of Verona. He also obtained certification in Thoracic Surgery. He was Clinical Fellow in Transplant Surgery at the University of Munich, Germany, then became Assistant Professor of Surgery at the University of Verona. He is currently full Professor of Surgery and Chairman of the Unit of Surgery, Pancreas Institute. During his career he has been Visiting Professor in many foreign universities, including Yale. He directs the residency program in General Surgery of the Verona University, and is responsible for the University of Verona Translational Surgery Lab.

Professor Bassi's experience covers all the surgical diseases of the pancreas, including acute and chronic pancreatitis, pancreatic cancer, cystic, endocrine, and other uncommon neoplasms. He recently developed radiofrequency ablation of locally advanced unresectable pancreatic cancer. Professor Bassi has performed and tutored more than 800 pancreatic resections, and several hundred other pancreatic operations (derivations for chronic pancreatitis, necrosectomy, bypass surgery).

Professor Bassi has authored more than 300 papers in peer-reviewed journals, and his impact factor (JCR 2012) exceeds 1000, and his H-index is 49. Furthermore, he is author of more than 150 book chapters, and was the Editor of 10 books. He has spoken as a faculty member in more than 250 national and international meetings. Professor Bassi is a Fellow of the American College of Surgeons (FACS), Fellow of the Royal College of Surgeons of England (FRCS), an honorary member of the German Surgical Society, honorary member of the Hellenic Society for Digestive Surgery, and honorary member of the Hungarian Surgical Society. He was President of the Italian Association for the Study of Pancreas (AISP), and is the President of the European-African Hepato-Pancreato-Biliary Association (E-AHPBA).

Professor David R Flum

David Flum is a gastrointestinal surgeon and outcomes researcher at the University of Washington. He holds the rank of Professor in the Schools of Medicine, Public Health, and Pharmacy, and serves as the Director of the



Surgical Outcomes Research Center (SORCE) and Associate Chair for Research in the Department of Surgery. He earned a Masters Degree in Public Health in the field of health services research while in the Robert Wood Johnson Clinical Scholars Program at the University of Washington. Dr Flum is an internationally recognised surgical epidemiologist and outcomes researcher – a leader in bridging clinical care and public health issues. His work is aimed at improving healthcare by studying the impact of interventional care by identifying processes of care that work helping increase their use.

Dr Flum serves as the Program Director of the NIDDK-funded, post-doctoral T32 training program in surgical outcomes research and is Principal Investigator for several research studies evaluating the mechanisms, impact and/or outcomes of surgery on obesity and diabetes. This includes the Longitudinal Assessment of Bariatric Surgery study (the first NIH -funded study evaluating efficacy and effectiveness in bariatric surgery), Mechanisms of Glycemic Improvement after Gastrointestinal Surgery, Feasibility, Efficacy, and Mechanisms of Surgical vs. Medical Diabetes Treatment, the Bariatric Outcomes and Obesity Modeling project (a multi-disciplinary Department of Defense-funded study evaluating the health policy and economic impact of bariatric operations), and the Calorie Reduction Or Surgery: Seeking Remission for Obesity and Diabetes project (an RCT of surgery and best medical therapy for diabetes, funded by the NIDDK). He is Medical Director of CERTAIN, a patient-centered research network focused on conducting comparative studies of healthcare treatments and technology.

Dr Flum is also the founder and Medical Director (2005-2011) and currently serves as Research and Development Lead of the Surgical Care and Outcomes Assessment Program (SCOAP). SCOAP is a quality of care improvement program providing hospital-specific data feedback and best practices regarding processes of care and outcomes to over 55 Washington State hospitals. He sits on the editorial boards of Surgery and the BJS and was Chair of the American College of Surgeons' Surgical Research Committee from 2008-2013. In 2011, Dr Flum was appointed to the Methodology Committee of the federal Patient-Centered Outcomes Research Institute (PCORI).

Mr Ian C Martin

Ian Martin is the immediate past-President of the Federation of Surgical Soecialty Associations (FSSA). He is a Consultant Oral and Maxillofacial Surgeon and Medical Director and GMC Responsible Officer at the City Hospitals Sunderland NHSFT.

Ian was a Cathedral Chorister at Chetham's Hospital School, Manchester, and gained a BDS and MBBS [Hons] at King's College Hospital, London. House jobs at King's were followed by a SHO post in general/plastics and T&O in Plymouth. He was then a Registrar on Merseyside, and a Senior Registrar at QVH East Grinstead. He was appointed Consultant in Sunderland, and a Senior Lecturer at Newcastle University. Ian's clinical interest is in Head and Neck Oncology and Microvascular Reconstruction.

Mr Martin's previous posts have included Clinical Coordinator Surgery and Lead Coordinator for NCEPOD (1997-2013), Chairman of the SAC and member, JCHST, JCSTD and intercollegiate examination board, Past Chairman and elected member of Council BAOMS, Immediate past President BAHNO, Immediate past President North of England Medico-Legal Society, Invited member of RCS England Council and member of the Review Implementation Group and a Member of the Forum of Surgery of Great Britain and Ireland. Ian is currently President of the European Association for Cranio- Maxillofacial Surgery (EACMFS), a Trustee of NCEPOD, a Member of Council of the Royal College of Surgeons of England, a Member of the Outcomes Advisory Board (HQIP), a Civilian Consultant Advisor for the Royal Air Force and the President designate of BAOMS.

Association of Surgeons of Great Britain and Ireland

TRAVELLING FELLOWS

For many years, the **BJS Society** has generously funded a Travelling Fellowship at the ASGBI International Surgical Congress. The aim of the fellowship is to allow a distinguished international clinician to review an element of practice in the UK and Ireland by visiting a variety of centres and delivering a report at the Congress on their observations and findings.

The Association is most grateful to the BJS Society for this generous sponsorship, and is honoured to have welcomed the following Travelling Fellows to the ASGBI Congress.

1996, Glasgow
THE UNMET RESEARCH NEEDS OF SURGICAL PRACTISE
Professor Sir Michael Peckham
(London, England)

1997, Bournemouth
LIVER DISEASE:
THE AFRICAN PERSPECTIVE
Professor Philippus Bornman
(Cape Town, South Africa)

1998, Edinburgh
SURGICAL TRAINING:
AN INTERNATIONAL PERSPECTIVE
Dr David Theile
(Brisbane, Australia)

1999, Brighton
SURGICAL TRAINING IN EUROPE: OFFSHORE ISLAND AND CONTINENT
Professor Huug Obertop
(Amsterdam, Netherlands)

2000, Cardiff
TRAINING IN THE UK:
AN AMERICAN'S VIEW
Professor Claude Organ
(California, USA)

2001, Birmingham
THE EMERGENCY SURGICAL SERVICE
Professor Abe Fingerhut
(Paris, France)

2002, Dublin
BASIC AND CLINICAL SURGICAL RESEARCH: A TRIBUTE TO EXCELLENCE
Professor David Bouchier-Hayes
(Dublin, Ireland)

2003, Manchester (three Fellowships)
ARTIFICAL BLOOD SUBSTITUTE
Professor Ernest Moore
(Denver, USA)

THE SURGEON AS IMMUNOMODULATOR
Professor Jonathon Meakins
(Oxford)

SURGICAL INFECTION
Professor Eugen Faist
(Munich, Germany)

2004, Harrogate
SURGICAL AUDIT AND THE QUALITY OF CARE
Professor Bruce Barraclough
(Sydney, Australia)

2005, Glasgow
EUROCRATS, EUROPHILES AND THE ISLAND RACE: MAKING SENSE OF THE EWTD
Professor Brian Rowlands
(Nottingham, UK)

2006, Edinburgh
PREPARING THE 21st CENTURY WORKFORCE: ADAPTATION TO EVOLVING CHALLENGES
Professor Barbara Bass
(Houston, USA)

2007, Manchester
TRAINING IN EMERGENCY SURGERY: INCOME OR OUTCOME?
Professor Kenneth Boffard
(Johannesburg, South Africa)

2008, Bournemouth
THE MAKING OF A SURGICAL ONCOLOGIST
Professor John Daly
(Philadelphia, USA)

2009, Glasgow
THE PROVISION OF EMERGENCY GENERAL SURGERY
Professor Torben Schroeder
(Copenhagen, Denmark)

2010, Liverpool
EMERGENCY GENERAL SURGERY IN UK AND FINLAND: A TALE OF TWO COUNTRIES
Dr Ari Leppaniemi
(Helsinki, Finland)

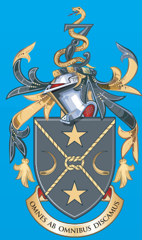
2011, Bournemouth
DEFINING EXCELLENCE IN SURGICAL TRAINING
Professor Jörgen Nordenström
(Karolinska Institutet, Sweden)

2012, Liverpool
REDUCING SURGERY'S CARBON FOOTPRINT
Professor Antonio Sitges-Serra
(Barcelona, Spain)

2013, Glasgow
MANAGING EMERGENCY SURGERY - ONE SIZE FITS ALL?
Professor Jonathan Fawcett
(Brisbane, Australia)

2014, Harrogate
GREAT SIMULATION
Professor Richard Reznick
(Ontario, Canada)

2015, Manchester
UNINTENDED CONSEQUENCES OF CANCER RECONFIGURATION
Professor Robert Padbury
(Adelaide, Australia)



OPENING ADDRESS BY HRH THE PRINCESS ROYAL

ASGBI, E-AHPBA and ATMS were delighted and honoured that HRH The Princess Royal consented to officially open the joint Manchester Surgical Week on Wednesday 22nd April 2015. Her Royal Highness spent almost four hours at the Congress, meeting visiting Presidents, speakers, delegates and International Bursary winners. HRH toured the industry exhibition, visiting the stands of the Association's Corporate Patrons. The Princess also attended the ATMS Guthrie Lecture, and kindly presented the 2015 Guthrie Medal to Mr Michael Crumplin.

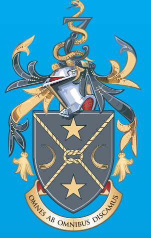
The following is a transcript of Her Royal Highness's Opening Address.

Manchester Surgical Week
'Patient Centred Care'

"I am delighted to join you today, and thank you very much for asking me. I feel that there may be a reason for this, as although I'm the least qualified as far as this audience is concerned, I am a patient, so I have that overview which might be quite important in this context. I think it's a really good decision to come to Manchester, which I think is an excellent city to choose for your Surgical Week as we've just been hearing, it is absolutely the right size to be able to bring so much together that is exactly what you face in your conference. That is fighting against the modern tendency and the necessity for super-specialisation in medicine, but that can often lead to separation and fragmentation and this event is really important to battle against that, so seeing ASGBI, E-AHPBA and the Association of Trauma & Military Surgery coming together to counter this trend is an enormous boost to those of us who come from that non-specialist and unqualified background.

But I hope that it would also create more expertise, more sharing of clinical practices, of experiences, but particularly comradeship and friendship. ***'Securing the Future of Excellent Patient Care'****, which was the report of the independent review into the future shape of medical training, found that patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings. From a patient's perspective, that certainly sounds encouraging; from a specialist perspective more of a challenge. So it is pertinent to see the engagement of the four Surgical Royal Colleges, international Colleges and so many Surgical Specialty Associations and delegates from the UK and from much further afield participating in this very diverse programme of scientific, clinical and professional issues. This provides the sound Continuing Professional Development for surgeons of today, and solid education for trainees who will follow as the doctors of tomorrow. Hopefully it will enable them to cope with the future global demands on healthcare which, of course, will include an enormous increase in knowledge and practice. I am particularly pleased to note the inclusion of a number of International Bursaries funding trainees from under-resourced countries to attend the Congress and to observe, through visiting local hospitals, the delivery of surgical services in the UK, a very important part of what you can do for the next generation.*

The breadth of the joint congress is also demonstrated by a focus on surgical outcomes and the opportunity to compare data, not just between individual clinicians and units, or different hospitals and Trusts, but potentially across countries or even continents. And it's that isn't it, the collection, the interrogation, interpretation and publication of outcome data that has been largely made possible by that rapid revolution of digital technology. This has also enabled the Manchester Surgical Week to be at the forefront of innovation through being delivered electronically via a dedicated app. Without the customary printed programmes, although I notice that actually... you do have a printed 'Pocket Programme' to tell you where you are and



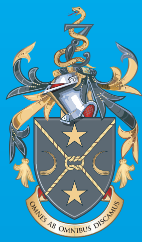
where you should be, which is probably quite important, and also without the often unwanted delegate bags ….. although I have a comment on that, this paper light approach has benefits, although frankly not to my speech writing, partly because the tablet doesn't fit in my handbag, that would require a delegate bag but I won't go there. But the advantages are, yes they can provide a modern interactive and more efficient service, and support a sustainable agenda, but it might have a possible downside, in many respects given the success of this app and the way it's been taken up I'm quite surprised, and hugely encouraged, to see so many of you here because you could have done it online. The only other possible advance in terms of having the app and the tablet constantly available is whether anybody is listening out there? You have to because this isn't on a website or online, so this is the only chance you get!

But it is appropriate that a number of publications and ***Issues in Professional Practice*** *booklets have been launched online during the Manchester Surgical Week and one of those is, of course, on* ***The Clinical Informatics Revolution****, and that is an issue for everybody. This last week I've been very much into smart cities, I feel reasonably well educated in this area, but there is no doubt that defining what you want from informatics, and how you're going to use that to benefit your particular areas, needs a considerable amount of work and a considerable amount of understanding and really only comes with a better understanding of the data you actually have and that's considerable and it is being added to all the time. Also assessing the art of the possible, is it always necessary, where do you make it simpler, how do you use all those extraordinary increases in technology and ability to make the best possible improvements in your particular spheres of activity. There is a definition of the difference of information, knowledge and wisdom which you probably know; knowledge is knowing that the tomato is a fruit, wisdom is knowing not to put it in your fruit salad! Sometimes these things are subtle, but the sheer weight of data and what you have to deal with makes those subtleties rather more difficult to put in.*

The second of these professional practice booklets is produced jointly by the Association of Surgeons of Great Britain and Ireland and the Association of Trauma & Military Surgery and is on ***Clinical Leadership*** *and this does show how different sectors of the profession, by collaborating at events such as these, can learn from each other for mutual benefit and for that of the populations they serve, but it is about pulling together the practice and turning that into better practice for everybody. I've had the opportunity of seeing the military operational experience at work in Camp Bastion, and the thing that strikes you is the teamwork, and the leadership that is required to make that teamwork work even better, and this is an area of clinical leadership which is key to everybody and how you develop that.*

The final booklet on ***Surgical Quality Assurance Meetings*** *has been produced in partnership with the* ***Confidential Reporting System in Surgery****, and I think aptly reflects the overarching theme of the joint congress, that of patient centred care. I would support that as a patient who is interested in care, although funnily enough it is the leaflet that I would find most difficult to understand, but those two things have to come together. It comes back to patients, people like me, although in my case, you'll be pleased to hear, I don't remember anything of the interventions that I've had courtesy of surgeons. I think you'd be pleased to hear that, but especially reconfirming at an event like this the importance of personal contact, human interaction, the interest that you feel is added to by actually being here in person to use your own experience and to talk about those with people, because so much of that information technically is available, but this kind of event is different, it is unique and it gives you unique opportunities.*

So, I'm delighted that you're here, and I would also like to congratulate the organisers because I think anybody who volunteers to run a congress like this knows what they've let themselves in for … but not entirely, and to get to this stage, well done. But in the end this is about the Manchester Surgical Week and I'm delighted to officially open it, certainly I wish you well with your deliberations, I hope you will find lots to take home with you, it'll be good for you as individuals, but perhaps even better for those who you will treat in the future. Thank you for being here today."



WELCOME LECTURE

The Association was delighted that Sir Richard Leese, Leader of Manchester City Council agreed to deliver the Welcome Lecture at the 2016 Manchester Surgical Week.

Sir Richard was born and brought up in Mansfield, Nottinghamshire. After graduating from the University of Warwick with a BSc. in Mathematics, he worked as a teacher in Coventry and as an exchange teacher in the USA before moving to Manchester to take up a post as a youth worker. He was employed variously in youth work, community work, and education research between 1979 and 1988. Sir Richard's political interests include devolution, place-based budgets and the links between economic development and social policy, developing open democracy and the community leadership role of local authorities; and the role of cities in creating a sustainable future. He has a number of additional responsibilities including Director of Manchester Airport Holdings Ltd, Vice Chair of the Greater Manchester Combined Authority, Chair of the North West Regional Leaders' Board, Chair of the Core Cities Cabinet and Chair of the LGA City Regions Board.

Sir Richard Leese, CBE

His interests outside politics include walking, cinema, music, and sport (as a spectator, principally Manchester City football and cricket). He is a regular runner and cycles to the Town Hall most days. Sir Richard was elected to Manchester City Council in 1984. He became Leader of the Council in 1996, having previously served as Deputy Leader, Chair of the Education Committee and Chair of the Finance Committee.

Sir Richard's Welcome Lecture is reproduced below:

"Your Royal Highness, Ladies and Gentlemen; welcome to Manchester.

I am delighted that you have chosen our city for your International Surgical Congress. I am also delighted to welcome the annual Military Surgery Conference, and it is excellent that the European and African Hepato-Pancreato-Biliary Association has chosen Manchester for its first biennial congress in the UK.

That all three events have come together here in this City to form the first Manchester Surgery Week is a tribute to the foresight of the leaders of all three organisations. May I say that this coming together of different organisations and the coming together of surgeons and academics is entirely appropriate for Manchester? This fits so well with the type of City we are.

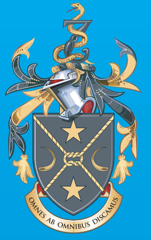
The movement that saw Manchester grow into a global city began with a coming together, in the late eighteenth century, of doctors from the City Infirmary and Unitarians from the Cross Street Chapel, just down the road from here. Together they formed the Manchester Literary and Philosophical Society which gave birth to a Mechanics Institution and to Owens College, which became Manchester University.

Despite its name, the Literary and Philosophical Society specialised in science, in particular science which was radical and practical. Radical, because the Unitarians were, by law, barred from Oxford and Cambridge, and also because the City was politically under-represented in Parliament.

Practical because, perhaps influenced by the doctors, it attracted scientists more interested in facts than theory, who wanted to bring science out of the academic establishments and into the real world. The Society attracted the likes of Dalton and Joule; beginning a tradition which later attracted here to Manchester, the likes of Rutherford, Turing and the discoverers of Graphine - Geim and Novoselov.

This history of Manchester as a city at the cutting edge of radical, practical change is, I'm pleased to report, alive and well today. There are two simple priorities for the Manchester of the modern era: One - economic growth. Two - all Manchester people connecting to, and benefiting from, that growth.

Manchester's performance has been strong in recent times. Over the ten years to the last census, Manchester was the fastest growing city outside London and, despite the recession, the economy of the Manchester City Region has fared better than other places outside of the South East. Over the next ten years, the City's population will continue to grow, and jobs are predicted to rise by 7%.



But our second priority is a longer, more difficult, journey. We have been performing well - more of our residents have been connecting to the City's economic growth and gaps on all the key measures between lives in Manchester and national averages have been closing - educational attainment, skills, crime and health outcomes have all improved. But, with the exception of education (where, at secondary level, we now equal national results), gaps have not closed completely - meaning that inequality of outcomes in the lives of Manchester people persist.

The greatest of these inequalities is health. The gap in life expectancy between Manchester and England is 3.9 years for men and 3.1 years for women. Deaths from circulatory diseases, cancers and respiratory diseases account for the biggest proportion of this gap.

Healthy Life Expectancy for both men and women in Manchester is also lower. Boys born in Manchester can expect to live, on average, 76.8% of their lives in "Good" health; girls can expect to live 71.0% of their lives in "Good" health. Compared to other places in the Country with best Healthy Life Expectancy, the men living here now can expect to spend 10.6% less of their remaining lives in "Good" health and Women 13.1% less.

So, radical change is still required; and radical change is being delivered through devolution and public service reform. We will achieve further growth and better lives for our residents by taking more control of our own solutions, taking responsibility for our own future; by Manchester standing on its own two feet.

This is challenging and changing the modern orthodoxy of England as one of the most centralised counties. All the evidence shows that counties which allow their cities more freedom to make their own policy and financial choices do better economically. But, we are not waiting for Westminster to see the light, we are forging for ourselves a new path of devolution.

On 3rd November last year, myself and the Leaders of the other nine local Councils in Greater Manchester, signed a Devolution Agreement with the Chancellor of the Exchequer to transfer powers from central government to local government and to create an elected Mayor for Greater Manchester. This is an historic agreement. It is the first substantive devolution of powers from central to local government after more than 30 years of powers flowing the other way.

This matters because it gives us more of the control we need to sustain growth through the improvements in transport and other infrastructure that business needs to access markets. It gives us more of the powers we need to provide the skills and support which business needs to create good jobs. We in Greater Manchester are better placed than Whitehall to understand and respond to the needs of the sectors of our local economy where the opportunities for growth lie. This includes life sciences and health, where we have world-leading research and innovation.

It matters because it allows us to reform public services so that we can help more of our people from families who have not been benefiting from Manchester's success for generations to at last start to connect to the growth being generated; to get the good jobs being created. We in Greater Manchester are better placed than Whitehall to understand how to align public services to the real needs and opportunities of local people and to pull services together into integrated packages bespoke to the needs of individual people and their families.

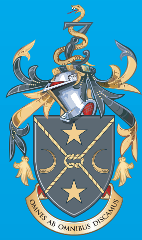
It matters because it gives us more of the influence we need to shape local neighbourhoods as places where people want to live and to stay in as they become successful and as they grow their families.

In short, devolution and reform is the key to continuing and growing the success of Manchester.

One part of the devolution agreement signed on 3rd November, was to develop a business plan for the integration of health and social care across Greater Manchester, including specific targets for reducing pressure on A&E and avoidable hospital admissions.

Since November, we have developed the health part of the agreement at remarkable speed - faster and further than any other part of the agreement. Less than four months later, on 27th February, we signed the Greater Manchester NHS and Social Care Devolution Agreement. The objective is to move us from having some of the worst health outcomes to having some of the best and closing the health inequalities gaps faster.

One of the reasons we were able to make such rapid progress was that our ambitions for Greater Manchester to take more responsibility for its own future coincided with the NHS Five Year Forward View issued by Simon Stevens late last year. Whilst making the case for additional resources to close the widening gap



between available resources, the costs of an ageing population and better, but expensive, treatments, the Five Year view also made the point powerfully that resources are only part of the answer. We need reform too. Simon Stevens also made the very clear and, in my view, correct point that one size will not fit all. Places that are able to innovate must be given the support and freedom to do so.

That set of views chimed beautifully with our plan in Greater Manchester. The way out of the funding crisis facing the NHS and social care services is through radical reform. I believe we have to integrate health and social care services in a more holistic, co-ordinated way. We have to reform the experience of patients and put carers and their families at the centre of how services are organised and delivered. We also need collaboration, not just competition, between Acute Hospital Trusts.

Let me give two examples of these reforms in action. Manchester's 'Living Longer Living Better' programme is transforming the services people can expect to support their independence. It is helping people to stay in control of their own lives and to get the joined-up care and support they and their family need to help them live well at home for as long possible. When people need care and support at home, the various staff from the NHS, from primary care and from social care should be coming as a co-ordinated team - all should know what the others are doing. This is the only way for support to actually help, instead of causing more stress for patients and their carers.

We are, therefore, bringing all community health and social care into a "One Team" approach. The focus is on proactive care in the community to keep people well enough not to need reactive and expensive hospital care or long-term residential social care.

In this scenario, devolution means integration of public services at neighbourhood level. Wherever possible, NHS and Council staff will be integrated into teams serving local populations of around 40k residents. Instead of the agency they work for, or a particular disease or type of support, staff and the care and support they provide will be organised around the place and the patients.

The One Team approach in the community will mean new ways of working for staff; a cultural shift in how different types of staff work together. And it will mean big changes to the support systems, for example IT systems and how information and intelligence is shared.

My second example is combining medical teams from separate hospitals into single teams. Greater Manchester has been consulting through its 'Healthier Together Programme' on options for these sorts of shared service arrangements for A&E support, General Surgery and acute medicine. The key to this is, of course, continuous engagement of clinicians and patients.

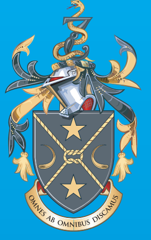
The opportunity we now have through the Devolution Agreement is to take these examples to scale. We will take integration of community health and social care to common standards across the whole of Greater Manchester. And we will take the concept of shared single teams across a wider range of acute services - again across the whole of Greater Manchester - improving services and lives for a population of over 2.7M.

It is the unacceptability of the inequalities in health outcomes that is driving us to scale up reform in this way. But so also are more the immediate pressures of the need to meet national quality and safety standards in all of our hospitals; and the reality of increasing demand - there were 90,000 more A&E attendances across Greater Manchester in 2012/13.

We can't ignore the budget pressures that this demand is creating for all of our acute trusts. But of course what really matters is having the clinical skills we need and the reality is that, even if money were unlimited, we could probably not recruit all the consultants needed to safely staff all services 24/7.

The scale of these challenges requires a radical and practical response, which is what the Devolution Agreement gives us. The Agreement is between NHS England, all Greater Manchester Clinical Commissioning Groups and all ten Councils. It provides a framework for devolution of all health and social care responsibilities to the CCGs and Local Councils within Greater Manchester. Crucially it is supported by all of the Acute Trusts across Greater Manchester.

Starting this month, there will be a year of collaborative working to achieve full devolution or delegation from April next year. This is just the first year of a five year journey. The duties of the NHS constitution and mandate will still apply. NHS services will, therefore, remain as part of the NHS, and social care will remain a statutory duty of the Councils. But it allows us to start to reshape how the annual spend on health and care in Greater Manchester (around £6bn per annum) is used - we can



align the budget to our priorities of reform. Decisions about Greater Manchester will be taken in Greater Manchester.

Why has this happened in Manchester? I think this goes back to the spirt of the City which the coming together of the doctors from the City Infirmary and Unitarians in the 1780s epitomised. The spirt of radical and practical science and reform. We have forged ahead of other places over the last few years because leaders from different sectors and different organisations have been determined to create our own future for Greater Manchester and not let others decide for us. We do this not for the sake of our organisations, but for the sake of the people and place of Greater Manchester.

This is not an overnight success. The ten Councils have been working hard at working together for nearly 30 years now. We have created even stronger governance, culminating in the creation of a new Combined Authority run by the Leaders of the ten Councils. This will now be strengthened by the agreement to move to an elected Mayor who will join the Combined Authority. We aim to replicate, over the next five years, the same depth of collaboration with our NHS partners - all our local experience has taught us that competition alone will not deliver the reforms we need.

And the coming together of practical academics, science and doctors is also alive and well. Manchester is the only place outside London and Cambridge to have an accredited Academic Health Science Centre. This collaboration between Manchester University and the leading teaching hospitals in Greater Manchester is of international significance, with over 940 collaborations world wide. More importantly, it is researching and developing new treatments which improve the lives of Manchester patients across our City and across the world.

So to conclude, it is magnificent to have you all here at the first Manchester Surgery Week. You could not have chosen a more appropriate City for your deliberations and discussions. I am sure some of the pioneering spirt of Manchester will pervade your proceedings."

REPORT FROM E-AHPBA

The 11th international congress of the European and African Hepato-Pancreato-Biliary Association (E-AHPBA) took place in Manchester, UK from Tuesday 21st to Friday 24th April 2015, and attracted 626 delegates. The meeting was co-located with the ASGBI International Surgical Congress and the ATMS Military Surgery Conference to make "**Manchester Surgical Week**" and was formally declared open by HRH The Princess Royal.

There was a very popular postgraduate course to kick-off the meeting with lectures from experts on core HPB topics, videos of the standard major HPB resections and an "MDT" where trainees were put in the spotlight, presented cases and asked to solve clinical problems.

The three days of the main programme featured important symposia across the breadth of modern HPB surgery including transplantation. There were symposia on "common" topics such as acute pancreatitis and gallstone disease, to sessions on newer developments in HPB such as down-staging chemotherapy for borderline resectable pancreatic cancer.

In addition to these symposia, the meeting featured updates from the International ALPPS congress that was held in Hamburg in February 2015 and also from the 2nd laparoscopic liver surgery consensus conference.

Key note speakers at E-AHPBA included Professor Marcus Buchler, Dr Bill Jarnagin from MSKCC in New York, Professor John Neoptolemos, Professor Rene Adam and a host of other international authorities.

Scientifically, the co-location with ASGBI was a great success in that jointly badged sessions were attended by delegates from both societies and E-AHPBA registrants had the opportunity to attend more General sessions. There were 13 free paper sessions and 400 e-posters allowing the younger generation of HPB surgical trainees to participate in the meeting.

The congress followed the recent ASGBI tradition of being "paperless" and this was well received by E-AHPBA members. The ability to interact with the congress app and use social media were popular innovations.

Congress feedback was uniformly very high with delegates commenting on the well-organised sessions featuring important speakers. The Presidential invitation dinner in a converted monastery in Eastern Manchester was a special evening with the venue retaining something of the calm and mystery of its earlier origins.

Remarkably, the only thing that was missing from the conference in Britain's wettest city was the rain, with congress being blessed with four days of sunshine.

Professor Ajith Siriwardena, MD, FRCS
Congress President, E-AHPBA 2015

When you use something other than Strattice™ Reconstructive Tissue Matrix for your patients' complex abdominal wall repair, you may risk more than you realise.

- Among survey respondents, Strattice™ Tissue Matrix reported 30% use, more than any other biologic[1]
- 1100 patient cases published worldwide*
- Less than 1% explantation rate[†]

Contact a LifeCell Business Manager today at www.lifecell.com.

* Searches performed on PubMed, Google, Google Scholar, and ScienceDirect® in September 2013 Each study was considered independent during calculation. Studies may contain overlapping patient populations.

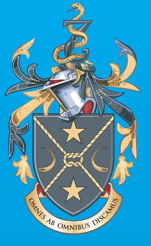
† <1% incidence of explantation reported in all peer-reviewed complex abdominal wall reconstruction articles.*

1. European Ventral Hernia study conducted by Millennium Research Group (MRG) on behalf of LifeCell Corporation in September 2013 to assess the clinical and market landscapew for ventral hernia repair (VHR) mesh products in Europe.

Before use, surgeons should review all risk information, which can be found in the *Instructions for Use* included in the packaging of each LifeCell™ Tissue Matrix graft.

LifeCell™
An Acelity Company

© 2014 LifeCell Corporation. All rights reserved. LifeCell™ and Strattice™ are trademarks of LifeCell™ Corporation
MLC 3895-EU/370772-2014



2015 ATMS GUTHRIE LECTURE

Mick Crumplin, the 2015 Guthrie Lecturer

This year marks the 200th Anniversary of the battle of Waterloo, and George James Guthrie (after whom the lecture is named) was The Duke of Wellington's Combat Surgeon. It was pertinent, therefore, that the 2015 Guthrie Lecture was an historical retrospective about Guthrie himself. The lecture was given by Mr Michael Crumplin, FRCS.

Michael Crumplin is a retired general, thoracic and upper G/I surgeon. Educated at Wellington College and the Middlesex Hospital, during his surgical career he had a special interest in education and examinations, serving as Chairman of the Court of Examiners of the Royal College of Surgeons of England and also on the board of UK intercollegiate examiners. He also served on the editorial board of the ***BJS*** and on Council of ASGBI. After studying medicine of the Revolutionary, Napoleonic and other wars for over 40 years, and having taken an interest in surgical history generally, he now devotes time to writing, lecturing nationally and internationally and advising students, research workers, authors and the media. Michael has published four books (one of them an account of George Guthrie's work in the Peninsular War), sundry articles and has acted as medical advisor for many media programmes and films. His principle purpose with surgical history is to promote interest in the human cost of war and the oft-forgotten efforts of military medical men. He is honorary treasurer and a trustee of the Waterloo Association and member of the official Waterloo 200 Committee; heading up and co-ordinating the educational and learning group for the commemorations of the 200th anniversary of the Battle of Waterloo. His next project is to create a medical exhibition on the battlefield of Waterloo, in the large farm that acted as the main British field hospital on 17th to 19th June 1815.

The following is a précis of the 2015 Guthrie Lecture.

George James Guthrie (1785-1856)

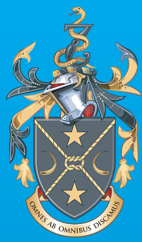
George Guthrie was probably Britain's greatest military surgeon, at least certainly during the long French Revolutionary and Napoleonic Wars (1793 to 1815). Born in London to Scottish parents on 1st May 1785, Guthrie had private schooling, conducted by a brilliant French Jesuit cleric, a certain Monsieur Noel, who taught him languages, mathematical and nautical skills. As a young teenager, Guthrie had an accident and it was thought that he might have a promising future as an army doctor by the surgeon who was treating him. So, at the young age of 13, he became apprenticed to Mr Phillips, a surgeon of Pall Mall, and to a renowned physician, author and teacher, Dr Hooper, who practised at the Marylebone Dispensary. In June 1800, young Guthrie was working as an unqualified surgeon's mate at the York Military Hospital, Chelsea. His experience of war-injured and sick patients began with treatment of the most severe cases who had just returned from the Helder expedition of 1799. Surgeon General Keate issued an edict that no mate should be working unqualified, and so Guthrie had to resign or face the examiners in London.

In March 1801, still only 15 years old, Guthrie passed the examination for membership of the Royal College of Surgeons of England and was appointed regimental assistant surgeon to the 29th Foot. Guthrie was, thus, the youngest to qualify for the membership examination and was the most youthful surgeon in the army!

The battalion was posted to Halifax, Nova Scotia, where Guthrie married and was promoted full battalion surgeon. He returned in 1807 and, en-route home, using his navigational skills, he saved his troop transport from shipwreck. Guthrie's regiment was then posted to the western Mediterranean to reduce Cueta (a Spanish base in North Africa). Portugal, Britain's oldest ally, was resisting Bonaparte's attempts at a comprehensive continental blockade against Britain. So Bonaparte ordered Marshal Androche Junot to invade Portugal, crossing Spain with a force of 25,000 men. On 2nd May 1808, the Spanish nation began a series of uprisings against the French, since Bonaparte had put his brother, Joseph, on the throne of Spain. The Spanish nation now joined Portugal in prosecuting a war with France, and the Portuguese government begged help from Britain. In August 1808, Guthrie accompanied General Sir Arthur Wellesley to Mondego Bay, in Portugal, to help the Iberian efforts against the several French occupying forces. The Peninsular War had begun.

A view from the Allied position at the Battle of Roliça, looking up at the French position

Guthrie had a huge exposure to war surgery throughout the Peninsular Campaigns. On 17th August, at the first action of the war in Iberia, he treated around 120 casualties at the Battle of Roliça. His tourniquet snapped during one amputation, and he thereafter eschewed the use of the instrument whenever possible - using purely gentle digital pressure to control bleeding, when necessary.



Wounded in both legs by musket ball at the victory at Vimeiro, he moved on to Lisbon and did not take part in the ill-fated retreat by General Sir John Moore's force to Corunna.

After a brief absence from Portugal, in the spring of 1809, Wellesley organised a lightning march north to eject Marshal Soult's force from Oporto. This succeeded, and Guthrie was instrumental in saving a Portuguese regiment from destruction after the crossing of the Douro. Wellesley soon marched off eastwards to counter yet another French advance under King Joseph and Marshal Victor and stopped him, in July, at Talavera. This battle resulted in many thousand British casualties. Guthrie placed his patients in smaller hospitals, fearing the spread of infection. He helped to organise the difficult withdrawal from Talavera, where Wellesley had defeated a French Army (for which he was created Viscount Lord Wellington). Unable to press home his advantage, and with his rear threatened by Marshal Soult in the north, he was forced to retreat. During the retreat, Guthrie was appalled at the low standard of surgery. He intervened to reduce numbers of unnecessary amputations, a stand that did not endear him to his colleagues. At Truxillo, mortality in his cases, especially that following amputation, was very much lower in his hospital than in the general hospitals.

The Battle of Talavera

Continuing the retreat to Portugal, Guthrie developed either benign tertian malaria or typhoid, but survived. He was invalided home in early 1810. Missing most of the year, including the Battle of Busaco and the army's retirement behind the Lines of Torres Vedras, he was later that year, promoted staff surgeon to Sir Lowry Cole's 4th Division. After Massena had been ousted from Portugal, Wellington had to fend off two French attempts to relieve, firstly Almeida (resulting in the battle of Fuentes de Onoro), then Badajoz (which led to the Battle of Albuera). In April 1811, Guthrie struggled at Albuera, being the only senior medical staff surgeon, and was overwhelmed with so many casualties after a mismanaged and very sanguinary affair against Marshal Soult's army. He worked tirelessly, treated thousands of casualties and toiled eighteen hours a day for a week.

In 1812, whilst Bonaparte was preparing to invade Russia, Wellington had next to capture the two strong border fortresses of Cuidad Rodrigo and Badajoz. Guthrie was present at Cuidad Rodrigo, where he met Dr (later Sir) James McGrigor, and then had much to do further south, at the third Siege of Badajoz. After the sanguinary and difficult capture of these two important border fortresses, Wellington could break out of Portugal and, at the 'El Alamein' of the Peninsular War, the Battle at Salamanca, Guthrie worked tirelessly in the baking hot fields for three days during, and after, the battle. In the city, he saw to it that some French prisoners were properly cared for. Local Spanish authorities had wilfully ignored several hundred wounded Frenchmen. Guthrie was furious at this inhuman reaction, which had clearly been sparked by the innate hatred of the French by the Spaniards. Guthrie obtained succour for the prisoners. Later, captured by the French in the Pyrenean campaign, he was released, when a French officer recognised the humane British medical officer who had helped him after Salamanca.

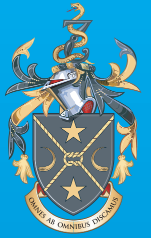
A surgeon - probably Guthrie - treating a patient at Talavera

After Wellington's failed siege at Burgos, in October 1812, the Allied Army had a difficult retreat all the way back to north Portugal, where McGrigor, Guthrie and the AMD struggled to get the army fit for the ensuing victorious campaign of 1813. Guthrie, to his chagrin, was posted to Lisbon, and was thus absent from the great victory at Vitoria and he also missed the sieges of San Sebastian and Pamplona. In Lisbon, he wrote on the management of syphilis without using mercurial compounds, disarticulation at the shoulder joint and diseases endemic in Iberia.

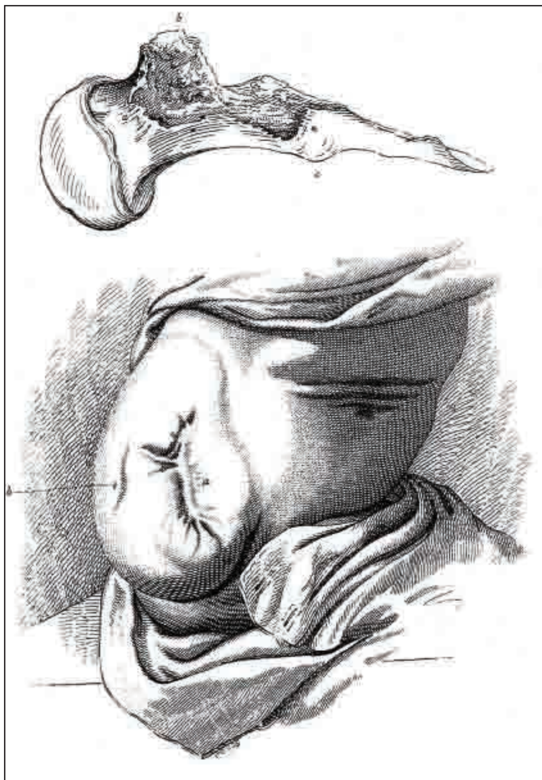
As Wellington crossed the Pyrenees, the northern ports of Santander, Bilbao and Passages were opened to the British. This facilitated supply and evacuation, as the campaigns of 1814 approached. The base of Lisbon was reduced in August 1813 and Guthrie came up to Santander to take charge of a large hospital, supplemented by around 700 extra beds, sent out with portable wooden hospitals from Britain.

Having chased the Imperial French Army out of Spain and back into France, in the spring of 1814, Wellington attacked Toulouse, held by Marshal Soult, sustaining heavy casualties. Guthrie was the senior surgeon after the Battle of Toulouse and again had charge of a general hospital in the city. He published meticulous results; overall mortality for 1,242 soldiers was only 146/1,242 (12%). Of interest, the mortality for officers was 3/117 (2.5%).

Guthrie, by now, as many others were, was exhausted by war and returned to the bosom of his



family. He wished to set up private practice in London and re-attended classes to familiarise himself with latest clinical practice. He was discharged on half-pay. In March 1815, Bonaparte escaped from the Isle of Elba and Guthrie did finally offer his services to the army once more for Napoleon's ultimately ill-fated 'Hundred Days' return that culminated in the Battle of Waterloo. He arrived in Brussels two weeks after the battle and consulted widely. He operated on only three Waterloo casualties - one in Britain, extracting a musket ball from the patient's bladder - and the other two in Belgium (as it is now). The first patient was a man with continued, deep-seated bleeding from the peroneal artery. Guthrie managed finally to stop the haemorrhage. The second case he operated on was a full disarticulation at the hip joint on a French prisoner-of-war, named François de Gay. The operation lasted half an hour. The patient lost around 700ccs of blood and made a full recovery, after suffering inevitable wound infection.



The entry wound (on the right buttock), avulsed head and neck of femur and the ultimate scar left after Guthrie's hip disarticulation of François de Gay.

Finally, then, the war was over and the second phase of this illustrious man's career was to start. In 1815 he published his book '***On Gunshot Wounds of the Extremities requiring Amputation***'. Rightly acknowledged as a pioneering military surgeon whose overall results were amongst the best of the period, some of his work remained in use up to the Franco-Prussian War.

Importantly, he understood the control of bleeding during surgery and was the first to show that both proximal and distal ends of a divided artery must be ligated after injury. He described gas gangrene and understood the proximal spread of sepsis, via the venous and lymphatic systems. After Salamanca, he showed that incision of the deep fascia in an infected swollen limb relieved tissue pressure on the arteries of the limb, threatened with ischaemia. He described the treatment of nerve injuries, stressing the danger of ligating the ends of nerves and describing the association with causalgia. At Santander, he also advocated the use of longer splints, in the case of fractured femur, to enhance better immobilisation and to reduce deformity.

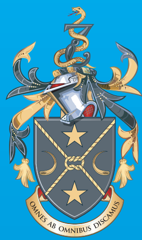
Guthrie in his thirties (left) and a few years before his death.

Guthrie went on to have a distinguished civilian surgical career, serving five terms as Vice President, rising to be President of the Royal College of Surgeons of London - then, later England - in 1833, 1842 and 1854.

Always at pains to teach military surgery properly, and desploring the lack of a national effort to do so, he gave lectures gratis over many years to military trainees. He had turned down a knighthood offered to him by the Duke of York in 1826, but was delighted to be elected an FRS. In 1828, he was appointed consulting surgeon to the Westminster Hospital, where he pursued a robust career. He developed an interest in ophthalmic surgery and helped found the Westminster Ophthalmic Hospital. He pursued issues of the College vigorously and was deeply involved with the Medical Act, the Anatomy Act and the new College Charter. Always a champion of the military medical men and the sick-poor of London, he was predeceased by his wife, who died of cholera in 1846. One of his three children predeceased him, dying of a stroke. Outlived by two children and very briefly married for a second time, Guthrie died of a chronic cardiopulmonary complaint on his birthday on 1st May 1856.

References

1. **Crumplin M**
   Guthrie's War, a Surgeon of the Peninsula and Waterloo
   2010, Pen and Sword Military, ISBN 978 1 84884 245 8
2. **Crumplin M**
   George James Guthrie: Wellington's Combat Surgeon
   2006, Journal of the Association of Surgeons of Great Britain & Ireland.
   http://www.asgbi.org.uk/download.cfm?docid=B3DDEE73-E1B4-40F2-972DE872CF8ABFA9
3. **Hurt R**
   George Guthrie: Soldier and Pioneer Surgeon
   2008, Royal Society of Medicine of London Press
4. **Watts J C**
   George James Guthrie, Peninsular Surgeon
   Proc. R. Soc. Med., 1961, 54(9), 764/8



HAS THE STANDARD OF CARE IN APPENDICITIS TREATMENT CHANGED YET?

A CROSS-ATLANTIC EXPLORATION

Anne E Pugel, MD and David R Flum, MD MPH

For over 130 years, the standard treatment of appendicitis has been removal of the appendix. The availability of high quality surgical services has effectively reduced this once life-threatening emergency to a limited-stay, and sometimes even outpatient, surgical procedure. However, throughout modern medical history, the treatment of uncomplicated appendicitis with antibiotics-alone, rather than appendectomy, has been advocated. In 1956, **Eric Coldrey**, reporting on his experience at Rotherham Hospital in Yorkshire, described the successful treatment of hundreds of patients with acute, uncomplicated, appendicitis using only penicillin and streptomycin [1]. Finding the outcomes of these "*conservatively*" treated patients "*quite similar*" to those having an operation, he concluded, "*One cannot help feeling our successors….may look back on us as having been too appendectomy-minded*".

For some clinicians and patients, it has been the circumstances of their illness that determined which treatment was offered. For example, the common and successful practice of treating Navy sailors and submariners who had no access to an operating room with "*antibiotics at sea*" [2], suggests the potential of this approach. A long-standing practice of treating patients with advanced appendicitis (e.g., inflammatory masses or phlegmons after perforation) with antibiotics-alone has also motivated investigators to evaluate these treatment options for patients with less complicated appendicitis.

In the last decade, five small RCTs performed in Europe [3 to 7] compared the efficacy of appendectomy to an antibiotics-first approach (with a 'rescue' appendectomy for those who have a deteriorating clinical course). All five RCTs demonstrate that antibiotics-first could help avoid appendectomy in most, with a similar length of stay, and without a higher rate of perforation. The recurrence rate was 10-37% in the antibiotics-first group at 7-12 months follow-up. One of the challenges in interpreting these studies is that crossovers within 48 hours from the antibiotics-first to the appendectomy arm ranged from 0 to 53%. This suggests that either the antibiotic-first regimen does not work as well in certain groups of patients, or that willingness to adhere to the antibiotic-first protocol varies considerably between different groups of clinicians and patients.

Each of these RCTs had methodological flaws that also limit their utility in informing decision making. These include questions about the adequacy of the randomisation technique and about how patients were selected for the study. The lack of a standardised endpoint and not enough subjects with sufficient heterogeneity to understand who is likely to respond to antibiotics-first also creates an opportunity for further important research. Perceived cultural, institutional, and clinical practice differences at the sites where these studies were conducted may also be limiting the uptake of this antibiotics-first approach. For example, in the United States, a recent study found that less than 1.5% of patients with uncomplicated appendicitis undergo this approach [8]. Though these RCTs have certainly advanced the field, significant gaps remain in the evidence and future studies are being planned in Europe and the United States.

To determine the likelihood that studies of antibiotics-first might actually influence patterns of care, investigators from the University of Washington recently partnered with ASGBI to conduct a survey of the Association's membership. The survey asked about ways in which these five RCTs have influenced clinical practices related to uncomplicated appendicitis. Nearly 200 surgeons responded (n=196) and 1 in 5 (21.4%) reported offering antibiotics-first to their patients with uncomplicated appendicitis in the last year. Surgeons who offered this approach estimated that 13% of their patients were offered antibiotics-first. Respondents proposed that, in their experience, 1 in 4 (24.9%) patients who began a course of antibiotics-first ended up requiring a rescue appendectomy within two weeks. Since all members of the ASGBI were offered participation in the survey (N=1,627) the low response rate for this survey (196/1,627) should be considered when interpreting these findings, and there is a possibility that those who responded are more likely to offer antibiotics-first.

There is very limited tracking of the practice of antibiotics-first and outcomes related to

antibiotics-first are not available (beyond the RCTs). Although limited in its cohort of respondents, this survey may offer the best view of the perceived "real world" use and success of antibiotics-first. The survey results indicate that, at least for those who responded, the five RCTs were influential in changing the longstanding practice of offering appendectomy. The survey also suggests the importance of determining the success of the procedure to help inform decision making and the willingness of the ASGBI community to support research initiatives. The investigators are most appreciative of this partnership with the ASGBI and thank the survey respondents.

References

[1] Varadhan K K, Neal K R, Lobo D N
Safety and efficacy of antibiotics compared with appendicectomy for treatment of uncomplicated acute appendicitis: meta-analysis of randomised controlled trials
BMJ 2012;344. PMID:22491789

[2] Rabin R, de Charro F
EQ-5D: a measure of health status from the EuroQol Group
Ann Med. 2001 Jul;33(5):337-43. PMID:11491192

[3] Eriksson S, Granström L
Randomised controlled trial of appendicectomy versus antibiotic therapy for acute appendicitis
Br J Surg 1995;82:166-9. PMID:7749676

[4] Styrud J, Eriksson S, Nilsson I, et al
Appendectomy versus antibiotic treatment in acute appendicitis. a prospective multicenter randomized controlled trial
World J Surg 2006;30:1033-7. PMID:16736333

[5] Turhan, A N, Kapan S, Kütükçü E, et al
Comparison of operative and non operative management of acute appendicitis
Ulus Travma Acil Cerrahi Derg. 2009;15:459-462. PMID:19779986

[6] Hansson J, Körner U, Khorram-Manesh et al
Randomized clinical trial of antibiotic therapy versus appendicectomy as primary treatment of acute appendicitis in unselected patients
Br J Surg 2009;96:473-81. PMID:19358184

[7] Vons C, Barry C, Maitre S, et al
Amoxicillin plus clavulanic acid versus appendicectomy for treatment of acute uncomplicated appendicitis: an open-label, non-inferiority, randomised controlled trial.
Lancet. 2011;377:1573-9. PMID:21550483

[8] Talan D A
Pilot Randomized Trial of Antibiotics vs Surgery for Treating Acute Appendicitis.
National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of the National Institute of Health (NIH). Project #1R21DK102048-01A1.

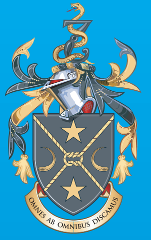
CONGRESS KEYNOTE CANCER LECTURE

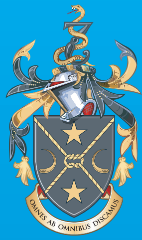
Professor Rakesh Jain

The Congress keynote Cancer Lecture was delivered by Professor Rakesh Jain on Thursday 23rd April 2015.

Dr Jain is regarded as a pioneer in the field of tumour microenvironment and widely admired for his seminal discoveries in tumour biology, drug delivery, in vivo imaging, bioengineering, and bench-to-bedside translation. He is known for uncovering the barriers to the delivery and efficacy of molecular and nano-medicines in tumours; for developing new principles to overcome these barriers; and then translating these principles from bench to bedside, and in the process, discovering new biomarkers and new strategies to improve the outcome further.

He is most celebrated for proposing a new treatment principle – normalisation of microenvironment – for treatment of malignant and non-malignant diseases characterised by abnormal vessels that afflict more than 500 million people worldwide. Dr Jain has developed the world's leading laboratory for the quantitative study of tumour microenvironment and the role of physical forces in tumour progression and treatment response. A mentor to more than 200 masters, doctoral and postdoctoral students from over a dozen different disciplines, and a collaborator of a similar number of clinicians and scientists worldwide, Dr Jain's findings are summarised in more than 600 publications, including four in ***Scientific American***. He has edited seven monographs on topics ranging from engineering to cancer. He serves, or has served, on advisory panels to government, industry and academia, and is a member of editorial advisory boards of 22 journals, including ***Nature Reviews Cancer*** and ***Nature Reviews Clinical Oncology***. Rakesh is a recipient of more than 60 awards. He received his bachelor's degree in 1972 from IIT, Kanpur, and his MS and





PhD degrees in 1974 and 1976 from the University of Delaware, all in chemical engineering. He served as Assistant Professor of Chemical Engineering at Columbia University (1976 to 1978), and as Assistant (1978 to 1979), Associate (1979 to 1983) and Full Professor (1983 to 1991) of Chemical Engineering at Carnegie Mellon University. He spent his 1983/1984 sabbatical year as a Guggenheim Fellow in the departments of chemical engineering at MIT, bioengineering at UCSD and radiation oncology at Stanford, and his 1990/1991 sabbatical as a Humboldt Senior Scientist-Awardee at the Institute of Pathophysiology of University of Mainz, and the Institute of Experimental Surgery of University of Munich. As of 1991, Dr Jain is the Andrew Werk Cook Professor of Tumor Biology (Radiation Oncology) at Harvard Medical School, and Director of Edwin L Steele Laboratory of Tumour Biology at Massachusetts General Hospital.

RE-ENGINEERING THE TUMOR MICROENVIRONMENT TO ENHANCE CANCER TREATMENT: BENCH TO BEDSIDE

For more than three decades, our research has focused on one challenge: improving the delivery and efficacy of anti-cancer therapies. Working on the hypothesis that the abnormal tumor microenvironment fuels tumor progression and treatment resistance, we developed an array of novel imaging technologies and animal models as well as mathematical models to unravel the complex biology of tumors. Using these tools, we demonstrated that the blood and lymphatic vasculature, fibroblasts, immune cells and the extracellular matrix associated with tumors are abnormal, which together create a hostile tumor microenvironment (e.g., hypoxia, high interstitial fluid pressure, high solid stress). Our work also revealed how these abnormalities fuel malignant properties of a tumor while preventing treatments from reaching and attacking tumor cells.

We next hypothesized that, if we could reengineer the tumor microenvironment, we should be able to improve the treatment outcome. Indeed, we demonstrated that judicious use of antiangiogenic agents - originally designed to starve tumors - could transiently "normalize" tumor vasculature, alleviate hypoxia, increase delivery of drugs and anti-tumor immune cells, and improve the outcome of radiation, chemotherapy and immunotherapy in a number of animal models. Moreover, our trials of antiangiogenics in newly diagnosed *and* recurrent glioblastoma patients supported this concept. They revealed that the patients whose tumor blood perfusion/oxygenation increased in response to cediranib – a pan-VEGFR TKI – survived 6-9 months longer than those whose blood perfusion/oxygenation did not increase. The normalisation hypothesis also explained how anti-VEGF agents could improve vision in patients with wet age-related macular degeneration, and opened doors to treating other non-malignant diseases harboring abnormal vasculature that afflict more than 500 million people worldwide (e.g., neurofibromatosis-2, which can lead to deafness; tuberculosis; plaque rupture; TB).

In parallel, by imaging collagen and measuring perfusion in tumors in vivo, we discovered that the extracellular matrix compresses blood vessels and impedes drug delivery in desmoplastic tumors (e.g., pancreatic cancer, hepatocellular carcinoma, certain breast cancers). We subsequently discovered that widely prescribed angiotensin blockers are capable of "normalising" the extracellular matrix, opening compressed tumor vessels, and improving the delivery and efficacy of molecular and nanomedicine. This finding offers new hope for improving treatment of highly fibrotic tumors and has led to a clinical trial at MGH on losartan and chemotherapy in pancreatic ductal adenocarcinomas (NCT01821729).

References

[1] **Jain R K**
Normalization of the tumor vasculature: An emerging concept in anti-angiogenic therapy of cancer
Science 307: 58-62 (2005).

[2] **Plotkin S R et al**
Hearing improvement after bevacizumab in patients with neurofibromatosis 2
New England Journal of Medicine 361: 358-369 (2009).

[3] **Snuderl M, et al**
Targeting placental growth factor/neuropilin 1 pathway inhibits growth and spread of medulloblastoma
Cell 152, 1065–1076 (2013).

[4] **Jain R K**
An indirect way to tame cancer
Scientific American 310: 46-53 (2014).

[5] **Jain R K**
Antiangiogenesis strategies revisited: From starving tumors to alleviating hypoxia
Cancer Cell 26: 605–622 (2014).

JOURNAL OF THE ASSOCIATION OF SURGEONS OF GREAT BRITAIN AND IRELAND: CONTRIBUTOR GUIDANCE

(As at Summer 2015)

The Association welcomes and encourages contributions from Fellows, and asks that potential contributors take the following guidelines into consideration.

Aims

The ***Journal of the Association of Surgeons of Great Britain and Ireland (JASGBI)*** is a regular publication which has evolved from the previously named ***Newsletter***. It aims to publish material of topical or general interest to members of the Association, which will promote and advance the reputation and functions of the Association to a wider professional audience.

JASGBI is not a peer reviewed, academic publication and is not intended as a vehicle for conventional academic papers. We nevertheless welcome a wide range of subject matter which may include:

- Articles of national and strategic relevance in relation to surgical training, teaching, career development, and issues in national politics, as they bear upon surgical and professional practice.
- Articles of topical debate.
- News from the Regions, and from affiliated Speciality Associations and Societies.
- Articles on international surgical practice, as observed by members of the Association on their travels, attachments and secondments.
- Historical articles of interest and relevance to surgeons.
- Personal experiences, parallel careers, hobbies, activities and achievements which are out of the ordinary, or which would fit our popular '**Secret Lives**' series.

This list is not exclusive. ***JASGBI*** is keen to encourage and help develop standards in professional writing and to act as a vehicle for new and original material.

Publication standards

Although ***JASGBI*** is not a conventional, peer reviewed academic publication, we subscribe wholeheartedly to the highest standards in respect of Publication Ethics and the elimination of the various forms of publication malpractice, as set out by the Committee on Publication Ethics (COPE) and the World Association of Medical Editors (WAME).

Material submitted to ***JASGBI*** should thus be original to the author(s). The editors reserve the right to submit any manuscript to peer review and to seek any amendments which are deemed to improve the presentation or content of the article to meet the standards and style of ***JASGBI***.

Article length

Please submit articles in **point size 12, Calibri font**. Each page of ***JASGBI*** can accommodate around 750 words with a small picture. While we are flexible as to content, articles should usually be of 2,000 words or less, with up to four original images and/or figures. In general terms, PowerPoint graphics detract from the quality of presentation and should be avoided.

Images and Copyright

We support full colour pictures. Please only submit pictures for which you own the copyright, or have the written permission to reproduce from the person who holds the copyright. If the source requires attributing, please include this in the article. Number the images and state the appropriate figure title in the correct location in the text. Please send images separately and as single files. Ensure images are high resolution (minimum resolution 640 X 480 pixels) and submitted in JPG format if possible.

You retain the copyright of your published material. Where multiple authors have contributed to an article, please submit written authority and agreement of all authors to the publication.

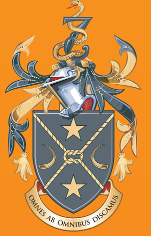
JASGBI reserves the right to use published material in the advancement of the interests of the Association, and to distribute such material both in hard copy in the printed journal and by other electronic means, as through the Association's website, to secure the widest possible readership.

Authors must provide a 'for correspondence' email address with any article submitted. This will be published alongside your article.

References

JASGBI is not a journal of reference and we can neither encourage nor support long lists of references in the Vancouver style. In general terms, we will publish no more than ten relevant references.

Copy should be submitted electronically and directly to the ***JASGBI*** Production Manager, Professor Nicholas P Gair, at ngair@asgbi.org.uk



Big discounts on Private Health Insurance for you & your family!

General & Medical Healthcare are delighted to be a preferred provider of Private Health Insurance for The Association of Surgeons of Great Britain and Ireland members and their families. As a preferred provider, we are able to offer substantially discounted Private Health Insurance.

We have a full range of policies from those that provide only in-patient benefits to fully comprehensive schemes and we have agreements in place with hundreds of hospitals and medical facilities throughout the UK.

For a quick, no obligation quote and to claim your discount visit:

www.generalandmedical.com/ASGBI

or call 0800 980 4601 and state 'ASGBI'

The discount may be withdrawn or varied at the discretion of General & Medical Healthcare.

in association with the Association of Surgeons of Great Britain and Ireland

©2015 General & Medical Finance Ltd. General & Medical Healthcare is a division of General & Medical Finance Ltd. Registered in England No 2421641.
General & Medical Finance Ltd is authorised and regulated by the Financial Conduct Authority. The firm reference is 579509 which can be checked by visiting www.fca.org.uk
ASGBI-V1.1

A Practical Guide to Improving

Outpatient Services

Delivering Outstanding Care & Meeting the CQC Inspection Standards

Monday 21 September 2015 Hallam Conference Centre, London

Book Now for a £250+VAT* reduced Rate for ASGBI Members

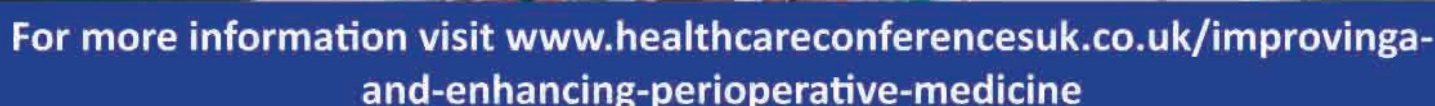
For more information visit
www.healthcareconferencesuk.co.uk/improving-outpatient-services

Improving & Enhancing

Perioperative Medicine

For all members of the Multidisciplinary perioperative medicine team

Monday 12 October 2015 Hallam Conference Centre, London



For more information visit www.healthcareconferencesuk.co.uk/improvinga-and-enhancing-perioperative-medicine

Setting up and running Virtual Clinics

Monday 19 October 2015 Hallam Conference Centre, London

Quote huck250asgbi when booking

*Terms and conditions.
Offer only applies to bookings on the advertised conferences and is not available to commercial organisations.

For more information visit
www.healthcareconferencesuk.co.uk/virtual-clinics

THE ART OF SURGERY: CAPTURING THE SURGICAL TEAM AT WORK

Drawings by Helen Purdie

For eight weeks during the summer of 2014, I sat within the operating theatres at Claremont Private Hospital in Sheffield drawing the surgical team at work. It was a very familiar environment for me and one in which I felt at ease. But with pencils and pens in hand? Now that was a new experience!

Until 2011, I had been working as a Surgical Care Practitioner (predominantly within Cardiac and Vascular theatres) and as a Senior Research Sister undertaking surgical education research in Sheffield. I will always see my time at the operating table as a huge privilege, and I was very much fulfilled by all the challenges that clinical research brought. However, in 2008 I picked up my paint brushes for the first time since leaving school twenty years earlier. I had done so with a conviction that I would become the artist I knew lay within me. Where did that conviction come from? I'm still not really sure. However, it was deep-rooted and by 2011 I had wound down my surgical and research work entirely and was practicing my art full-time.

Figure 1: The Scrub Nurse and the Surgeon, June 2014

My early paintings involved many rather intense self-portraits, as I tried to come to terms with my changing identity. Inevitably, and with some relief, the focus of my work began to become more outward looking. My confidence in different techniques grew and I realised how much I enjoyed drawing as well as painting. Whilst my body of work continued to grow, I kept coming back to wanting to depict the surgical team at work.

As well as the very tactile memories of my own surgical practice, I had also spent long hours observing trainee surgeons and the surgical team in the operating theatre for research purposes. I had been the coordinator and an independent assessor for the HTA study, headed by Professor Jonathan Beard, concerned with methods of work-place based assessment of trainee surgeons within the operating theatre [1]. The PBA (Procedure-based Assessment) and OSATS (Objective Structured Assessment of Technical Skills) assessed the trainees' predominantly technical skills whilst the NOTSS (Non-technical Skills for Surgeons) tool assessed their purely non-technical skills within four categories; situation awareness, decision-making, communication and leadership. I found this work engrossing, and was deeply fascinated to observe how teams interacted. It was this aspect of surgery that I most wanted to explore artistically.

Figure 2: Hip Replacement Surgery 4, July 2014

I had been concerned that the practicalities of getting a drawing project within the operating theatre off the ground may have been almost insurmountable. For this reason I kept it on the back burner for quite a long time. Thankfully, a major motivation to see it come to fruition presented itself in the form of an exhibition of Barbara Hepworth's Hospital Drawings from the 1940s at the Hepworth Gallery in Wakefield in 2013 [2]. Her works of the surgical team were exquisitely tender and compassionate, and left a lasting impression. Early in 2014 I visited the Tate Britain Reading Rooms. At my request, they had kindly pulled from their archives 30 years of correspondence between Barbara Hepworth and Norman Capener, the orthopaedic surgeon and Vice-President of The Royal College of Surgeons of England with whom she had collaborated for her hospital drawings. He had operated on her daughter, and they went on to have an enduring friendship. He bequeathed his Hepworth drawing ***Concourse (2)*** 1948 to The English College. I had the pleasure of viewing this work closely at the College, when I went to discuss my plans to undertake a drawing project in the operating theatres with the curators at the Hunterian Museum.

Despite my previous concerns, implementing the project was straightforward. One of the surgeons in Sheffield suggested I discuss the project with the Director at Claremont Hospital Sheffield, Mr Andy Davey. I presented him with a robust proposal which covered all aspects of consent and governance and which conformed to Good Clinical Practice (GCP) guidelines. The project was

passed by the Hospital's Medical Advisory Committee, after which I began the process of informing staff and patients.

On the day of surgery, I would meet with the surgeon and anaesthetist on the ward and take written consent from their patients for me to be present drawing during their surgical procedure. It was made clear that patients themselves would not be personally identifiable in any of the drawings. Patients and staff alike embraced the project with enthusiasm. Indeed, many patients actively expressed their strong support for such an unconventional approach to capturing the surgical team at work.

I had originally intended to make sketches in the operating theatre that I then planned to work up into more finished pieces in my studio, similar to the way in which Barbara Hepworth had worked. However, once I began drawing within theatres, I realised that I was really enjoying expressing the immediacy of what I was witnessing. The marks I made on my paper almost felt incision-like at times, especially those with my pen. My technique, whether using pen or pencils, had to be rapid and no drawing took much more than an hour, confined ultimately by the length of the surgical procedure itself. Some took only a minute or two and consisted of no more than a few lines – powerful in their very simplicity.

Figure 3: Ankle Stabilisation Surgery, June 2014

Much of my interest lay in capturing the interactions and togetherness of the team; their communication, gestures and movements, their awareness and decision-making. However, my attention also rested on single team members at times when I became more focussed on their integrity as individuals.

What emerged, over those eight weeks, was a collection of 67 drawings. These were exhibited at Claremont Hospital in September 2014. Patients and staff who had participated in the project were among those who attended the opening. The collection was subsequently exhibited in the Winter Gardens, Sheffield with much interest and engagement from the general public.

A selection of the drawings will also be shown at The Royal College of Surgeons of England within their exhibition '**Surgeons at Work: The Art of the Operation**' which extends until September 2015. Also, some of you will, hopefully, will have seen the drawings, along with prints and copies of the book (***Figure 4***) at the ASGBI International Surgical Congress that was held in Manchester in April.

I am grateful to all the operating theatre staff at Claremont Hospital who gave their permission for me to capture their practice. This demonstrated an openness and faith in my sincere intentions. I witnessed nothing but hard work undertaken with considerable professionalism. My greatest thanks go to all the patients who consented to me being present during their surgical procedures; they allowed me into their very private experience within the operating theatre with trust and generosity beyond measure.

References:

[1] Beard J D, Marriott J, Purdie H, Crossley J
Assessing the surgical skills of trainees in the operating theatre: a prospective observational study of the methodology
Health Technol Assess 2011; **15**(1)

[2] Hepburn N
Barbara Hepworth: The Hospital Drawings
Tate: London; 2012

Note:
Helen Purdie's work can also be viewed and purchased on her website:
www.helenpurdie.co.uk

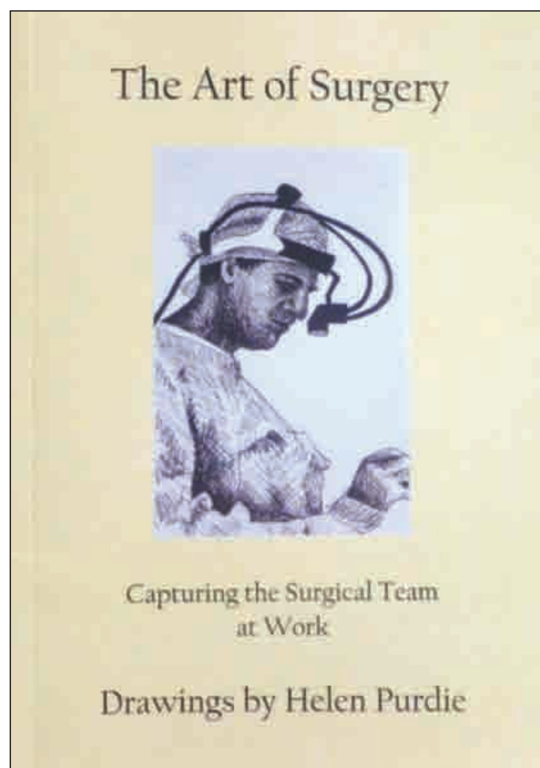


Figure 4: The book **'The Art of Surgery: Capturing the Surgical Team at work. Drawings by Helen Purdie'** *published August 2014*

BRITISH SURGICAL ASSOCIATION: SURVEY OF INTEREST

Surgeons, like many clinicians in today's NHS, are unhappy. Morale is at an all time low. There are many reasons for this: a perceived loss of professionalism, a culture of fear and intimidation in the work place and perhaps most importantly, a perception that surgeons are no longer in control of their own destinies. These are often determined by non clinical staff and politicians for whom cost containment is the absolute priority.

Whilst surgeons frequently point the finger of blame for their altered circumstances to our political and managerial masters and mistresses, much opprobrium also falls upon Colleges and Specialist Associations. How often does one hear the accusation "what do the Colleges or the Associations do for me?".

The problem here is defining what surgeons expect from Colleges and Associations. If it is certification, examination, maintenance of standards, development of crafts skills or encouragement of research, then really surgeons have no reason to gripe. The Colleges and Associations throughout the UK and Ireland actually perform these tasks with considerable aplomb and have done so for many years. The perception that they are glorified dining clubs for an aging elite is simply wrong!

If, however, surgeons are disgruntled because they feel no-one is looking to their professional interests as defined by their terms and conditions of work, or their salaries and pensions, or job contracts, or disciplinary procedures then they may have a point. Colleges and Associations are largely Charities and as such their actions are determined by the Charity Commission which specifically states that their activities must be for the benefit of the public and not exclusively for their surgeon members. Of course, there is inevitably some fudging of the boundaries and Colleges and Associations frequently justify activities on the basis that some benefit will accrue to patients as a secondary benefit to helping surgeons. But the inescapable fact is, and is often not appreciated by surgeons, that the Colleges and Associations are effectively powerless to intervene on surgeons' behalf with respect to terms and conditions of service. This latter is the role of the BMA which is the recognised trade union for medically qualified individuals. And, as is well known, surgeons are not particularly well represented in this organisation which is largely comprised of general practitioners.

For these reasons, I and others* suggested some years ago that consideration should be given to the creation of a "British Surgical Association (BSA)". We recognise that surgeons are traditionally conservative with a small "c" and are usually reticent to become involved in matters appertaining to trade unions. Also, we recognise that there are already arguably too many surgical Colleges and Associations and speciality groups. Nonetheless, numerous discussions have occurred and we were advised that no progress could be made on this suggestion without some verification that there was support for this idea in the surgical community. Hence, this survey.

A letter inviting surgeons to complete the survey was sent out on behalf of the FSSA from all 10 Specialty Associations. It read as follows:

Re: British Surgical Association: survey of interest

As many of you will be well aware, there has been discussion in recent months about the suggestion that the UK would benefit from the creation of what has been called "a British Surgical Association".

The aim of such a Professional Association would be to act as a 'Trade Union' for surgeons and to look after their interests irrespective of Surgical Royal College or Surgical Specialty Association affiliation. As such, it would be able to involve itself in matters relating to terms and conditions of service, contracts of employment, litigation, insurance and other matters which the majority of Surgical Colleges and the Associations are effectively excluded from on the basis of their charitable status.

A BSA would emphatically and specifically not be in competition with the Surgical Colleges or Associations, as these have remits relating to professional standards, education and membership activities and are not permitted to act, in any way, as a trade union. Indeed, it is apparent that any potential success from a BSA would only occur if it existed in harmony with the Surgical Colleges and Associations.

We have been informed that there is no theoretical impediment to Surgery as a defined craft Profession establishing its' own trade union.

For your information, the subject of BSA has been informally discussed with Presidents of all four Surgical Royal Colleges as well as informally with members of government and ACAS.

We are advised that an important preliminary step in establishing a BSA would be to substantiate the fact that there is popular support within the Profession for such a move. Hence the need for a survey.

This proposal (to sample surgical opinion using a survey distributed to members of all 10 speciality associations and facilitated by FSSA) has been discussed by the executives of all speciality associations.

We are grateful to you for your cooperation and would welcome any comments.

The questions were as follows:

1. Please state grade (Consultant / NCCG / trainee)
2. Number of years in present appointment (<1, <5, <10, <15, <20 years)
3. Do you agree that terms and conditions of service for surgeons should be considered separately to those of other specialities
4. Do you consider that terms and conditions of service are adequately dealt with at present
5. Would you support, in principle, the establishment of a "British Surgical Association"
6. If 'yes' would you agree that such an Association should be independent of Colleges and Specialty Associations but work closely with them

Results

Over 1500 responses were received.

A total of 82% were consultants. As regards years in practice approximately 10% were within 1 year of appointment

and then there was an even distribution of about 20% each for the bands up to 5, 10, 15 and 20 years respectively.

When asked the question *"do you agree that terms and conditions of service for surgeons should be considered separately to other specialities?" 78% said yes and 22% no.*

In answer to the question *"do you feel terms and conditions of service are dealt with adequately at present?" 85% said no and 15% yes.*

Question 5 asked "would you support, in principle, the creation of a British Surgical Association?", 82% said yes and 18 %, no.

The final question asked: *"if yes, would you agree that such an Association should be independent of Colleges and Speciality Associations but work closely with them?" No less than 95% said yes and 5% no.*

A total of 496 responses included free text. These are shown in full on the FSSA website (http://fssa.org.uk/BSAsurvey/responses). The majority were in support of the suggestion that a BSA should be established. The most commonly recurring theme was that surgeons were poorly represented and that the BMA was not fit for purpose from a surgical perspective.

There was a vocal minority who argued that we already have an ample sufficiency of representative associations and do not need anymore.

Discussion

Notwithstanding "survey fatigue" which afflicts most of us, this survey generated over 1500 responses in less than a

month. There is absolutely no doubt that surgeons are disgruntled about their terms and conditions of service and a majority of respondents were very supportive of the concept of a British Surgical Association.

These results were discussed at a recent meeting of the FSSA. Three important points were raised:

1. The fact that a survey shows a professional group are unhappy with terms and conditions of service may simply be a reflection of low morale throughout the NHS
2. The results might have been different if we had included a question asking whether or not surgeons would be prepared to pay a fee to join a British Surgical Association
3. It was pointed out that a notable feature of the free text responses was that very many were critical of the BMA. Perhaps therefore these results are a manifestation of discontent with the BMA rather than an appeal to create another association. In this regard I emphasised that reference to the BMA was deliberately omitted from the questions as I felt this would have inappropriately detracted from the main issue.

The FSSA have agreed that the next step should be to meet with the BMA in an attempt to determine whether or not they are prepared to specifically consider surgeons concerns. In the absence of any progress, then further enquiries would be made about other options; these include affiliation to another existing union, the formation of a voluntary union which can negotiate on members' behalf without using legal procedures and usually in liaison with ACAS or formation of an independent statutory union. Recognition as a statutory union necessitates application to a Central Arbitration Committee and needs as a basis proof it would be likely to attract a majority in favour in a ballot. This survey achieves that!

Comments received with interest.

Professor John MacFie, President of the Federation of Surgical Specialty Associations, June 2015

Mr Paul Blair	President, VS
Mr David Burge	President, BAPS
Mr Michael Davidson	President, BAOMS
Mr Tim Graham	President, SCTS
Mr Richard Kerr	President, SBNS
Mr Nigel Mercer	President, BAPRAS
Mr John Moorehead	President, ASGBI
Professor Tony Narula	President, BAO-HNS
Mr Mark Speakman	President, BAUS
Mr Ian Winson	President-elect, BOA

*acknowledgements

In particular to Professor Nick Gair, CEO of ASGBI who made informal enquiries of regulatory authorities to

determine if there was any legal impediment to the proposed BSA and who was informed that the concept was perfectly feasible.

THE NATIONAL FOOD SERVICE: A CAUTIONARY TALE

By Carving Knife

The Second World War catalysed a major reform in the allocation of food and food-related services across the UK. German submarine and maritime surface raiding warfare had led to a catastrophic disruption of the food supply chain. This in turn led to the introduction of a highly efficient, explicit and equitable food rationing system to ensure that basic dietary needs were met for all citizenry. A paradoxical benefit of this naval siege of a proud island race was that dietary related indicators of health have never been surpassed. The island itself floated several inches higher relative to mean sea level than it does today.

Prior to the War, the provision of food services across the UK was very patchy from one town to another, and based primarily upon independent chip shops. The wealthy would seek out gastronomic excellence in the wonderful restaurants and with the top culinary experts who worked around Barley Street in Central London. For the remainder it was (cooking) pot luck (pot noodles themselves had yet to be introduced to the working and commuting classes).

Following the return of an army of veterans who had enjoyed the wonders of Corned Beef Hash and Cheese-Possessed in military ration packs, the Churchill Government was thrown out in 1945 in favour of an idealistic government who believed fervently in equality for all through state direction and interventionism, rather than through market forces in food production and distribution. Citing the experience of wartime rationing, the Government determined to establish the National Food Service, on the basis that access to good food was a fundamental human right, and that control of access and distribution of food was a fundamental obligation of Governments, regardless of cost.

The incoming government calculated that, once the fair and even allocation of potatoes and of dandelion, burdock and nettle soup had been ensured across the nation, along with a weekly supply of a glass of orange juice and an apple through the community clinics for the nation's obscenely healthy children, the need for the National Food Service would wither away to nothing. A nirvana of healthy, long-living citizens would have been achieved.

In the afterglow of war, the firebrand Secretary of State for Food and Agriculture recognised that there would be resistance to change from the regional chip shop owners and from the celebrity London Chefs. He therefore pledged to "stuff their mouths with jolly tasty and creamy chocolate cake" until his political goals had been achieved, and until disease and pestilence had been eradicated from across the Green and Pleasant Land.

Unfortunately, this much revered, and now legendary, political "Scourge of the Independent Caterers" had failed to recognise that all life is finite, and that those living longer would need more specialised, vitamin rich, blended and pureed foods as they grew older. Moreover, technological brains, released from the shackles of designing better bomb sights, devised wholly new and unforeseen forms of food additive, food substitute and food addiction; and the means of delivering salt and sugar rich chocolate and caviar to every palate in the country.

Public and Popular Demand for the outputs of the NFS grew. The purpose of the single National Food Service Distribution Centre (NFSDCs) in each town - often housed in imposing Victorian brick buildings - changed from handing out the occasional bag of potatoes, to meeting an insatiable demand for every conceivable foodstuff. Attempted rationing by waiting times was addressed by bureaucratic fiat. No one would have to wait for any form of foodstuff for longer than a prescribed time, and staple foodstuffs such as milk and bread would have to be supplied by the NFSDCs within two weeks of an application.

Despite proclamation after proclamation, and many worthy Inquiries, Canute could not hold back the tide of Consequences. The citizenry grew increasingly angry at the disruption to the flow of its basic and advanced entitlements. Letters were even written to the ***Guardian*** and ***Independent*** newspapers.

Despite huge sums of public and taxpayer's money being thrown at the NFS, service standards of this National Icon began to crumble. Individual NFSDCs began to come under rigorous scrutiny for failings in their services, with regular outbreaks of food poisoning and the distribution of food which was increasingly past its sell by date. A few brave and backwards looking souls, descendants of wartime organisations such as the Long Range Digestive Group, the Special hors'd'Oeuvres Executive, the Sub(way) Marine Service and the Special Alimentary Service, would occasionally surface to question the status quo, but would then disappear back into their hiding places in remote caves and forests.

Nevertheless, such was the power of belief of a population which had grown to believe that free access to any form of food at the point of consumption and at the taxpayers' expense was a fundamental human right: and such was the fear of loss of power, influence, control and recognition of "Gastronomic Excellence" by politicians, and the nation's Culinary Elite: that no-one dared to challenge the status quo or to take up intellectual arms against this "Grande Alliance" of the Public, Politicians and National Food Providers.

The NFSDCs continued to struggle to meet ballooning demand for food from citizens of all ages; who had increasingly refined and

demanding tastes; and who increasingly came from far beyond the Sceptred Isles for free food provision.

Meanwhile, the new 1945 Government had soundly rejected proposals for a parallel national service for health, on the basis that the supply of health services was far too complex and fundamental a challenge to be nationalised or to be left under the control of a monopolistic State body. In any case, there was no public or popular demand for such a radical step. Left alone from state direction or intervention, a grand diversity of health provision outlets grew and thrived upon competition in every village, town and city, from the corner medicines shop to the Michelin starred health restaurants.

Small health shops gradually coalesced into large and highly competitive chains of independent supermarket health chains, with several major health outlets, easy access and free car parking on the outskirts of every town and city. Inside each emporium, citizens would rarely queue for more than a few minutes for access to every conceivable health cure at competitive costs.

The risks of the incredibly diverse health industry were wholly borne by the commercial bodies and their shareholders rather than the taxpayer. In recent years, costs were being driven even lower in the health provision industry by challengers to the super health market majors by European chains including, in a grand twist of irony, low cost specialist suppliers from Germany.

Occasionally, the great and the good of the National Food Service would look up from their email browsers and their committee papers, and glance out through misted windows to the supermarket health emporia across town.

A National Food Service which was no longer free at the point of use, or which was no longer universal in its promises of all services to everyone?; in which competitive market forces were unleashed?; and in a country in which individual citizen responsibility for food consumption replaced restrictive state directives and allocations? In which the citizenry had to regulate its health consumption through insurance based systems? In which personal responsibility for health was inculcated from the cradle to the grave?

A cold shudder went down the collective NFS political and corporate spine; it can't happen here?

PREVENTT (Preoperative intravenous iron to treat anaemia in major surgery) is a UK-based multicentre randomised controlled trial. PREVENTT is funded by the NIHR Health Technology Assessment programme with support from the Surgical and Anaesthetic Clinical Research Networks.

Background

Anaemia is common, affecting 30-60% of patients undergoing major surgery. The current standard of care is to treat anaemic patients with a peri-operative blood transfusion. There is growing evidence that preoperative anaemia is associated with increased length of hospital stay, and post-operative complications and mortality, whilst predicting the need for blood transfusion. Blood transfusion may not be the best solution, since this has also been associated with morbidity and increased cancer recurrence. Well established in renal medicine, intravenous iron can cause a rapid rise in haemoglobin of up to 2g/dl within two weeks and small cohort studies have shown benefit in a range of surgical settings.

Aim

PREVENTT aims to assess whether a single preoperative dose of intravenous iron treats preoperative anaemia and reduces the need for blood transfusion in the peri-operative period. Further endpoints shall measure whether this treatment improves patient health and improves recovery.

Methods

PREVENTT is a multicentre RCT. Eligible patients are those undergoing elective major open abdominal surgery of over one hour in duration. Patients identified as anaemic 10-42 days before their planned date of surgery are randomised to receive either 1g iron (ferric carboxymaltose) in 100ml normal saline or 100ml normal saline as placebo. Administration takes 15-30 minutes as an outpatient procedure and the patient is blinded to the trial treatment. This is the only intervention; there is no change or impact upon the centre's surgical or post-operative management of patients. Data is collected throughout the patient's admission including blood transfusion events, post-operative care and length of stay. Patients are followed up at eight weeks and six months post operatively during routine surgical follow-up, or this can be performed by telephone.

The primary endpoint for PREVENTT is peri-operative blood transfusion. Secondary endpoints include post-operative complications, morbidity scoring, length of stay, health related quality of life and costs, amongst others.

Overall, the study is aiming to recruit 500 patients across 30-35 sites. We currently have 25 sites open to recruitment and we are looking for further sites in the UK to participate in the trial. Please contact the Chief Investigator, Toby Richards at toby.richards@ucl.ac.uk.

Details and the protocol are available at http://preventt.lshtm.ac.uk/

This project was funded by the National Institute for Health Research Health Technology Assessment (NIHR HTA) Programme (project number 10/57/67).

RECONFIGURING CLINICAL SERVICES: THE EVIDENCE FOR ACUTE AND ELECTIVE SURGICAL SERVICES

Lara Sonola

INTRODUCTION

The pressure to reconfigure clinical services in the NHS is growing significantly as organisations seek new ways to deliver sustainable care. Implementing service change carries clinical, financial and organisational risks, and it is vital that clinicians involved in planning and implementing service reconfiguration use available evidence and professional guidance to decision-making.

A new paper ***The reconfiguration of clinical services: what is the evidence?*** published by The King's Fund, seeks to collate the research literature, clinical guidelines and professional guidance in a number of service areas and highlight where further evidence is needed. We identified five interlinked factors which need to be taken into account when embarking on clinical service change – workforce, cost, quality, access and technology, and have grouped the evidence under these themes as well as identifying key service interdependencies.

This work expands upon research conducted as part of a forthcoming study funded by the National Institute for Health Research (NIHR) which analysed over a hundred reviews produced by the National Clinical Advisory Team (NCAT) between 2007 and 2012. NCAT were a small, independent team of clinicians who provided clinical assurance of local reconfiguration proposals within the NHS. The NIHR research assessed the process of clinical assurance and the extent to which NCAT's advice was supported by evidence and professional guidance.

This article focuses on the evidence we identified to support the configuration of acute surgical and elective surgical services, as well as drawing upon NCAT's advice, and highlights key gaps in the evidence base which need to be addressed.

ACUTE SURGICAL SERVICES

Within acute surgical services, the majority of local proposals reviewed by NCAT sought to concentrate acute services onto fewer sites and separate acute services from elective care. These changes were largely driven by cost and workforce factors linked to safety concerns, for example ensuring that sites had sufficient medical cover to conduct out of hours assessment and surgery safely.

Quality

Outcomes from emergency surgery can vary considerably between units and mortality rates increase by 10 per cent when patients are admitted at weekends. There is some evidence that hospitals with higher volumes of surgical patients have better outcomes, however the mechanism by which is happens is not clearly understood. The application of known improvement techniques such as operating room checklists, and access to high quality peri-operative and post-operative assessment may be a more effective way to improve outcomes than centralising services.

Workforce

There is good evidence that early consultant involvement in and assessment of emergency surgical patients prior to surgery improves outcomes. Rapid access to consultant acute surgical opinion was supported by NCAT and the Royal College of Surgeons of England also advocate 24hr onsite surgical opinion in hospitals accepting unselected medical emergencies. The National Confidential Enquiry into Perioperative Deaths (NCEPOD) recommends that hospitals admitting emergency surgical patients should be able to staff their operating theatres and critical care services 24/7.

Key clinical and service interdependencies

Acute surgery was found to be a key service interdependency of acute medicine as it enables rapid diagnosis and treatment to improve outcomes. Guidance from the Royal College of Physicians (RCP) recommends the establishment of acute medical units (AMUs) which consolidate clinical and support services in a clinical team working closely alongside critical care staff to co-ordinate medical care for acutely ill patients. Ideally, these teams should be co-located with the emergency department on an 'emergency floor'.

Evidence from NCEPOD clearly demonstrates that a lack of access to critical care beds can be a key factor in perioperative death, while the Royal College of Surgeons of England also state that hospitals undertaking surgery should have the appropriate intensive care provision to support the anticipated emergency surgical workload. NCAT were strongly supportive of the position that access to critical care/anaesthesia and acute medicine should be available 24/7 for acute surgery.

ELECTIVE SURGERY

Within the proposals reviewed by NCAT to reconfigure elective surgery, almost all proposed separating elective surgery from acute and emergency services to create a 'cold' site with elective surgery and centralising acute services on the 'hot' site with a critical mass of senior staff, critical care and diagnostic services required to support them.

The main drivers of reconfiguration were costs and workforce pressures. Cost drivers involved plans to cut costs or increase their income from elective surgery, while workforce pressures arose from a need for senior surgical cover across multiple sites or in order to provide 24/7 consultant cover.

Quality

Our review of the evidence found that separating elective surgical care from acute and emergency services can improve efficiency and reduce cancellations due to the increased predictability of cases and access to senior cover. However, there was a caveat that these efficiency gains could be affected by patient case-mix and levels of demand.

The research evidence was supported by guidance from the Royal College of Surgeons of England in 2011, which suggested that it could *'result in earlier investigation, definitive treatment and better continuity of care, as well as reducing hospital acquired infections and length of stay'*. NCAT were also strongly supportive of these proposals to develop elective care centres.

Workforce

There is early evidence which indicates that non-medical staff, such as surgical care practitioners or GPs with a special interest in surgical procedures, can provide safe care for minor surgical procedures.

Access
There is some research evidence which indicates that patients will choose a provider which is further away, if the care is of better quality or can be accessed more quickly.

Key clinical and service interdependencies
We found good evidence on the importance of ensuring access to critical care facilities. Effective management of complications, including rapid transfer to an intensive care unit (ICU), was a key determinant of surgical patient outcomes. Elective surgical units without comprehensive critical care facilities or senior cover from consultants should not undertake complex surgery or accept patients deemed 'high risk' for minor procedures. NCAT often commented that elective units should implement rigorous clinical risk assessment procedures to ensure they maintained the appropriate case-mix of patients.

Professional guidance from the Royal College of Anaesthetists advises that anaesthesia delivered within elective settings should be consultant led, and that services require access to diagnostic and pathology services to support diagnosis and treatment.

THE POTENTIAL OF TECHNOLOGY

In both acute and elective surgery we found some promising early evidence for models of care employing technology to provide remote access to specialist opinion, for example tele-consults with senior staff based in a clinical hub, or using tele-monitoring within ICUs. Although this is emerging research, these technologies have the potential to mitigate against pressures to centralise services and facilitate local access to specialists.

WHAT HAVE WE LEARNT?

Within acute surgery, those embarking on service change should ensure that all patients have access to early consultant review and assessment and there are sufficient numbers of consultant surgeons and anaesthetists, alongside the requisite supporting services, to supervise operations 24 hrs a day, 7 days a week. While centralising services is one route to achieve these staffing levels and can improve outcomes, there is strong evidence for the use of surgical checklists to maintain consistency as well ensuring that all patients receive high-quality pre and post post-operative care.

Separating elective surgery from emergency admissions can be more efficient and cost effective, and the evidence indicates can it can also improve the quality of care. Elective units with full critical care facilities should have a robust clinical assessment process in place to ensure that they do not treat high-risk patients or conduct complex procedures.

CHALLENGES AHEAD

Overall, our review of the evidence indicates that access to senior clinical input has a significant impact on outcomes of care, particularly for higher risk patients or care delivered out of hours. Many of the proposals to reconfigure services sought to centralise services in order to improve access to senior cover, and more research is needed on the numbers and type of staff required. NCAT tended to support plans seeking to centralise acute services to secure sustainable surgical rotas. However, they often pointed out that these plans needed to be informed by robust data on patient flows.

While the evidence supporting the separation of elective surgery from acute services on the basis of quality and safety was fairly clear; we did not find any evidence to indicate the optimum size of such facilities or the wider impact this separation may place on an organisation or hospital site. Further studies into the cost and clinical effectiveness of different service volumes for stand-alone elective surgical facilities would be beneficial.

We found real gaps on the impact of service change on cost, which was surprising given the interplay between cost and workforce as a driver of service change. While the evidence should be taken into account when considering changes to clinical services, stakeholders are likely to value quality, cost, workforce and access differently. Where the evidence is not clear, arguably it is more important to build consensus on the best service model for the local population.

Further reading

1. **Imison C, Sonola L, Honeyman M, Ross S**
   The reconfiguration of clinical services: what is the evidence?
   The King's Fund (2014).
2. **Imison C, Sonola L, Honeyman M, Ross S, Edwards N**
   Insights from the clinical assurance of service reconfiguration in the NHS: the drivers of reconfiguration and the evidence that underpins it. A mixed methods study. National Institute of Health Research report HS&DR – 12/5001/59 (forthcoming).
3. **Findlay GP, Goodwin APL, Protopapa K, Smith NCE, Mason M**
   Knowing the risk: a review of the peri-operative care of surgical patients: summary.
   London: National Confidential Enquiry into Patient Outcome and Death (2011).
4. **Bell D, Lambourne A, Percival F, Laverty AA, Ward DK**
   Consultant input in acute medical admissions and patient outcomes in hospitals in England: a multivariate analysis.
   PLoS ONE, 8(4): e61476 (2013).
5. **Royal College of Surgeons of England**
   Emergency surgery: standards for unscheduled surgical care. Guidance for providers, commissioners and service planners.
   London: Royal College of Surgeons of England (2011).
6. **Royal College of Surgeons of England and the Department of Health**
   The higher risk general surgical patient: towards improved care for a forgotten group. Report of the Royal College of Surgeons of England/Department of Health Working Group on Peri-operative Care of the Higher-Risk General Surgical Patient.
   London: Royal College of Surgeons of England (2011).
7. **Mayer E, Faiz O, Athanasiou T, Vincent C**
   Measuring and enhancing elective service performance in NHS operating theatres: an overview.
   Journal of the Royal Society of Medicine 101 (6): 273–7 (2008).
8. **Kjekshus LE, Hagen TP**
   Ring fencing of elective surgery: does it affect hospital efficiency?
   Health Services Management Research 18 (3): 186–97(2005).
9. **Ereso A, Garcia P, Tseng E, Gauger G, Kim H, Dua M, Victorino G, Guy T** 'Livetransference of surgical subspecialty skills using telerobotic proctoring to remote general surgeons'.
   Journal of the American College of Surgeons 211 (3): 400–411 (2010).
10. **Lilly C, Zubrow M, Kempner K et al**
   Critical care telemedicine: evolution and state of the art'.
   Critical Care Medicine 42 (11): 2429–36 (2014).

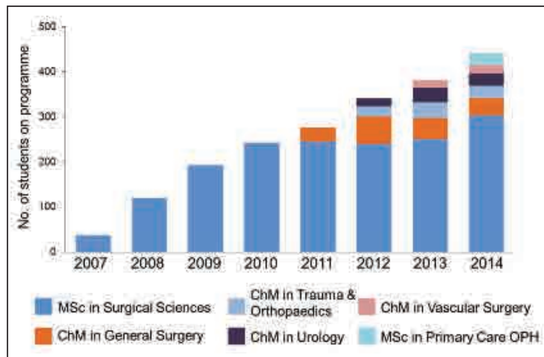
Lara Sonola was an author of The King's Fund's report, '***The Reconfiguration of Clinical Services***', in her previous role as a Senior Researcher at the Fund. This report is available at:

www.kingsfund.org.uk/publications/reconfiguration-clinical-services

The report draws on research funded by the ***National Institute for Health Research (NIHR) Health Services and Delivery Research Programme*** (project number 12/5001/59).

FURTHER SUCCESS AND RECOGNITION FOR ESSQ

In the past year, the Edinburgh Surgical Science Qualification has enjoyed record recruitment of surgical trainees who see the Masters in Surgical Sciences as being the ideal way to support their early professional and academic development as they approach the crucial milestone of the MRCS examination. The reduction of clinical exposure in the workplace has enabled this innovative distance learning programme to complement the traditional acquisition of clinical knowledge. An e-learning platform uses virtual case scenarios based on common surgical conditions to support students through use of discussion boards sustained by expert eTutors. The three-year online Masters programme is flexible and is delivered part-time. It enables the trainee to receive academic credit for research activity that may not require the trainee to take time out from clinical training. That the programmes appear fit for purpose does not seem to be in doubt. There has been an increase in recruitment year-on-year, and very positive feedback from trainees.



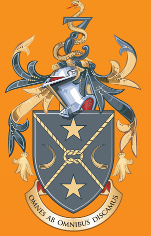
The MSc has now been taken up by 675 trainees in 43 different countries over the last 8 years, and graduating students have been shown to achieve higher success rates in the MRCS examination. The University of Edinburgh and the Royal College of Surgeons of Edinburgh (RCSEd) have now gone on to develop five further online Masters programmes, of which the ChM in General Surgery may be of interest to ASGBI members. This programme is intended to meet the needs of trainees later in their surgical training since the content of the two year course is closely aligned to the FRCS curriculum. The ChM has just received accreditation by the Royal Australasian College of Surgeons.

Although targeted at the UK training programmes, it has been astonishing to observe the increasing global outreach of the Masters programmes. The programmes have enjoyed extensive international collaboration, including partnership with Australasia and Malta. Scholarships have been created to improve access to surgical education in some of the poorest countries. Africa, in particular has benefited from being offered sustainable outreach support through funding from Johnson & Johnson, the Scottish Government and Physicians for Peace. Widening access has been achieved locally through joint bursaries through the Association of Surgeons of Great Britain and Ireland (ASGBI) and, most recently, the Association of Surgeons in training (ASiT).

The MSc in Surgical Sciences and ChM in General Surgery have been at the core of a series of surgical distance learning programmes that have re-shaped the landscape of postgraduate surgical education. This has been recognised previously by a number of educational awards, but was further acknowledged last year with the award of the Queen's Anniversary Prize for Higher and Further Education.

More information on the programmes can be obtained at:
www.essqchm.rcsed.ac.uk

To register interest, please contact:
chminfo@rcsed.ac.uk



ESSENTIAL SURGICAL SKILLS IN MADAGASCAR:

Partnering Mercy Ships to deliver surgical training in resource poor settings

Jack Broadhurst
General Surgical Trainee, University Hospital Southampton

Marc Bullock
Fulbright Royal College of Surgeons of England Research Fellow and General Surgical Trainee, University Hospital Southampton

The **Lancet Commission on Global Surgery** report brings into sharp relief the asymmetry which exists in provision of surgical care across the globe. One of the four key domains examined by the commission was access to training and education for surgical practitioners. The report recommends that, in order to engender more durable benefits for local people, non-governmental organisations (NGOs) should in future have training and education 'hardwired' into their healthcare delivery programs. It seems, therefore, that in resource poor settings the scale of the challenge cannot simply be defined in terms of numbers of personnel, the level of investment or the quality of infrastructure. Medical education plays an equally important role.

In November 2014, ASGBI and Mercy Ships, in partnership with the Royal College of Surgeons of England and ASiT, hosted an inaugural essential surgical skills course aboard the ***Africa Mercy*** Hospital Ship moored at the port city of Toamasina on the eastern coast of Madagascar.

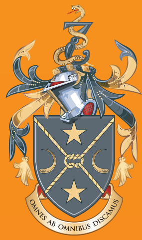
Mercy Ships is a global healthcare charity established in 1978, and the course was conducted aboard their largest ship to date, The Africa Mercy.

Mercy Ships is a global healthcare charity which has been active in the world's poorest communities since 1978. The *Africa Mercy*, their largest ship to date, will remain in Madagascar for eight months in which time they anticipate performing approximately 1,700 procedures including maxillofacial surgery, plastic and reconstructive surgery, paediatric orthopedics, general and ophthalmic surgery. The ship accommodates an average crew of 450 volunteers and contains 72 patient beds, a theatre suite, a CT scanner and state-of-the-art laboratory facilities.

Although well accustomed to delivering high standards of surgical care, the provision of medical education is a new departure for Mercy Ships. The course was devised and convened by two Wessex general surgical trainees, with the support of ASGBI. Although conducted in French, the content would be familiar to anyone in the early stages of surgical training in the UK, focused as it was on first-principles, basic technique and patient safety. Each course lasted for two days, and was divided into eight modules. The format combined brief lectures on key topics such as 'the safe surgery checklist' and 'the sterile surgical field', with more prolonged practical skill sessions using surgical equipment donated by Johnson & Johnson. At the end of each module, participants were asked to complete simulated surgical tasks using the standard knot-tying and suturing techniques which they had learned.

In total, fifteen local healthcare professionals took part in a highly practical course, comprised of eight modules over two days.

The fifteen people who took part in the course were from highly varied backgrounds, both geographically and in terms of surgical experience. Recruitment was conducted in advance by Mercy Ships



volunteers and was open to anyone who might be required to perform surgical tasks as part of their daily practice. This meant that as well as receiving the chief of surgery of a local hospital, the course also catered for personnel with minimal surgical training but whose duties at times included caesarian sections, trauma care and the treatment of superficial sepsis.

In total, fifteen local healthcare professionals took part in a highly practical course, comprised of eight modules over two days.

What was interesting, from the pre- and post-course appraisals, was that all participants appeared to take something positive away with them. Those with very little experience learned how to do basic treatments safely, and more experienced surgeons learned new techniques to help improve their practice. Certainly, the fact the course was so heavily oversubscribed and that experienced surgeons also signed-up, appeared indicative of a strong desire to access continuing professional development (CPD) in resource poor settings.

Skill stations included intestinal anastomosis and arterial patches as well as knot tying and basic suturing technique.

The participants were extremely generous in their praise for the course and approved of the small group structure which enabled the instructors to provide one-to-one support. Suggestions for improvement included the provision of written materials in French, so that participants could share their experience with others. The feasibility of training the trainers (TTT) was also raised, as several individuals felt the course format would translate very well to their home institutions. These suggestions, which will be incorporated in future courses, chime with the recommendation of the Lancet commission and highlight an opportunity to extend participation in CPD to many more healthcare professionals.

For their part, the course instructors were delighted by the warm welcome they received both from course participants and the staff of the *Africa Mercy*. They were particularly impressed with Mercy Ships' organisation and administrative capabilities - which promise to deliver the same high standard educational facilities wherever in the world the ship is docked.

Judy Polkinhorn, Executive Director of Mercy Ships UK, said:

"We are immensely thankful for the work of ASGBI and the Royal College of Surgeons of England. After the course's success there has been a great deal of enthusiasm, especially from the surgical trainees, to continue this collaboration and we are now looking at the ways in which we can do this. The skills and knowledge gained through such courses will undoubtedly help to improve the healthcare of local communities and transform the lives of so many people, many of whom are in need of life-saving surgeries."

Mercy Ships are committed to providing continued training and mentorship for healthcare professionals in resource poor settings and, given the success of the inaugural essential surgical skills course, ASGBI and Mercy Ships in collaboration with the Royal College of Surgeons of England and ASiT are offering surgical trainees from all specialties the opportunity to apply for faculty roles. Courses are scheduled for September and November 2015 aboard the *Africa Mercy*. Applicants must demonstrate an interest in humanitarian surgery, strong language skills and a proven track record in medical education. ASGBI has kindly agreed to meet the costs of transport to and from the capital Atananarivo and Mercy Ships will provide food, lodging and return travel to Toamasina.

To register your interest, please contact Mr Marc Bullock at:

skillsharesurgery@gmail.com

Bespoke **specialised insurance** for high value homes and cars...

LONMART
INSURANCE

WHEN DID YOU LAST REVIEW YOUR HOUSEHOLD INSURANCE?

Do you think you are paying too much?

Lonmart Insurance is proud to have been appointed as the provider of Household & Contents Insurance for the Association of Surgeons of Great Britain and Ireland.

At LONMART, we provide bespoke insurance coverage for private and corporate art collections, as well as specialised insurance for high value homes, general contents and high value cars.

At LONMART, we understand that you need a specialist independent insurance partner who is as passionate about protecting your assets as you are and one who understands the risks you face. Personal service has been at the core of everything we do for over 30 years and our specialist broking team will ensure that you have the right coverage at the right price.

As an independent broker, we are not tied to any one provider, which gives us the freedom to work with the market's best insurers, appraisers and valuers. This enables us to offer you a more competitive, bespoke solution that will ensure you are fully covered, should the worst occur.

For a quotation and to receive your **10% discount**, please click on the attached link, alternatively call Richard Outhwaite 0207 204 3639 or Diana Webster on 0207 204 3662.

Please remember to **quote ASGBI** in order to obtain your discount.
(Please note further discounts are available premium dependent.)

For more information, visit: **www.asgbi.org.uk/lonmart**

PERIOPERATIVE MEDICINE: EVOLVING THE MODEL OF SURGICAL CARE

Dr Mevan Gooneratne
Dr Caroline Moss
Dr Marta Campbell
Dr David Walker

Faculty members of the University College London Masters Programme in Perioperative Medicine

www.ucl.ac.uk/surgery/periopmed

Meeting the Ambitions of Surgery

The continual development of new surgical techniques has resulted in the exploration of new horizons in treatment for the surgical patient. Novel advancements have now allowed patients, previously deemed unsuitable for certain interventions, to undergo potentially life-saving surgeries and to no longer fall victim to their disease. However, the surgical population is ageing and invariably encompasses a host of comorbidities. Nonetheless, this population understandably attempts to seek a cure from surgical programmes that continue to challenge the boundaries of a patient's physiological reserve. It is not surprising, therefore, that national reports [1, 2] continue to identify the suboptimal management of such a population. It can be seen that, whilst societal expectations of surgery remains great, there is now a well-defined population of patients that are exposed to the risk of adverse outcomes, including death, during their perioperative journey. This group, termed 'the high-risk' surgical population, is growing in number and is only destined to increase further.

The Importance of the High Risk Surgical Patient

Although the definition of the 'high-risk' surgical patient varies, they may be characterised as; having multiple comorbidities, are often elderly, who undergo major surgical interventions and have a predicted surgical mortality of greater that 5% [3]. The failure to accurately assess and characterise the in-hospital requirements for a good outcome prior to surgery for this demographic, not uncommonly results in patient care which is 'reactionary' in nature and leads to a 'failure to rescue' [4] when complications occur. **Pearse et al** [5], identified that, whilst the high-risk patient accounted for only 12.5% of the surgical population, this subset went on to constitute 83% of total surgical mortality. These findings were supported in the 2011 National Confidential Enquiry into Patient Outcome and Death (NCEPOD) [1] report confirming a 6% mortality for the high-risk surgical patient, which rose to nearly 25% following emergency theatre [1]. This is a striking statistic when compared to cardiac surgery, and its reported mortality of just 1% to 2% for a similar demographic [3].

This somewhat alarming realisation with regards to the degree of patient mortality in the high-risk population is unfortunately not exclusive to the United Kingdom. The EuSOS [6] study controversially demonstrated a similarly high mortality in this demographic across 498 hospitals in Europe, with only 73% of those that died having ever received critical care treatment during the course of their perioperative management. The variability in these outcomes may reflect a lack of standardisation with regards to the perioperative management of the high-risk individual.

Early Identification and Vigilance

These studies suitably demonstrate that complications, including severe ones, are a constant feature of major surgery. While attempts to prevent their eventuality remains important; the ability to identify those at risk at an early stage and to subsequently manage them effectively with foresight, has a major bearing on patient outcomes. In 2011, in conjunction with the Department of Health, The Royal College of Surgeons of England produced a report entitled '***The Higher Risk Surgical Patient: Towards Improved Care in this Forgotten Group***' [3]. Advocating the early recognition of the high-risk surgical patient, the report attempted to standardise patient management by encouraging policies and protocols to ensure that high-risk surgical patients were paid due attention during the perioperative period.

Although disconcerting risk factors can be established with an early consultation with the patient, continual attempts have been made to explore methods to accurately and reliably identify the high-risk patient. The use of scoring systems such as the Portsmouth Physiological and Operative Severity Score for the enUmeration of Mortality and morbidity (P-POSSUM) and

the Surgical Risk Score (SRS) [3] have been used to predict risk of surgical morbidity and mortality, but their use to predict risk at extremes of age and beyond 30-days remains unreliable [7]. Risk scoring systems predict population risk, as opposed to the individual risk to the patient; hence their application into the clinical arena remains unclear.

Attempts to individualise patient risk has been less than conclusive. The use of cardiopulmonary exercise testing (CPET) has received much attention since it was demonstrated, in the early nineties, that an anaerobic threshold of less than 11 mls/kg/min was associated with an increased surgical mortality [8]. Nonetheless, as a tool it has received mixed reviews and its use as a predictive indicator awaits further investigation. Equally, the use of biomarkers and patient genomics also requires further exploration, but nonetheless the notion of a bespoke perioperative pathway catering to a patient's specific needs, based on validated test, remains the ideal to ensure best patient outcomes.

A Patient Centred Approach

Of late, there has been a deliberate Government drive to move away from a paternalistic approach to patient care to adopting a more patient centric one. In response to the White Paper '***Excellence and Equality: Liberating the NHS***' [9], the Government produced '***Liberating the NHS: No decision about me without me***' [10] in 2012, which highlighted the greater need for patient involvement when deciding about their own healthcare. This combined with the early engagement of other pertinent specialities, other than anaesthesia and surgery, would help facilitate a balanced decision making process, with the patient firmly placed at the centre. It is hoped that this multidisciplinary approach, combined with focused informed consent, would not only provide individualised evidence based advice and support, but would also incorporate, in essence, patient values and ideals.

There is now an increased focus on measuring outcomes that hold importance to patients. Since 2009, the NHS Patient Reported Outcomes Measures (PROMS) Programme [11] has collected patient-centric data on basic aspects such as pain, anxiety and types of complications. This is a concerted move away from the traditionally measured outcomes of morbidity and mortality, which may limit our understanding of what may be considered a good outcome following surgery. The data collected provides a useful resource for those considering surgery, especially if they are deemed to fall within the high-risk category once stratified.

The Rise of the Perioperative Physician

It can be clearly seen that, in the face of evolving surgery and a more challenging demographic, the current model of surgical care may no longer be able to adequately serve its population. The simple principles of shared decision making, informed consent, the early identification of risk and appropriate postoperative management are not, however, novel concepts. Unfortunately, with increasing public expectations, variable resources and reduced training times, the traditional perioperative model has become out-dated.

It is for this reason a new model of care has now been proposed. The professional development of the 'Perioperative Physician'; a doctor from any base specialty, trained to support and manage the entire surgical pathway from the moment surgery is contemplated through to hospital discharge, and perhaps beyond, has been advocated. Such an individual would be seen as playing an instrumental role whilst complementing existing surgical activity, as this overarching perspective provides a unique overview of the patient journey. Although yet to be supported with robust evidence of better patient outcome, it offers a new model of care where the early identification of risk and allocation of resource, in advance of surgical intervention, provides an important strategy to avoid potential harm.

The challenge will be to refine existing protocolled care pathways to be both sensitive and adaptable to individual patient needs, moving away from a *'one size fits all'* approach, while attempting to maintain a visible pathway where practice variance is minimised. In order to reduce such variance, these pathways must make better use of the available supportive care, e.g. Post-Anaesthetic Care Units (PACU), in a pre-emptive manner, rather than a reactive one. If the move towards an overarching specialist team is to have any

positive impact, the process will benefit from strong clinical leadership and a determination to collect, analyse and act on data effectively for clinical improvements.

Surgeons have a unique insight with regards to the patient journey, as invariably they are there at the beginning, middle and end. It is for this reason that they are well placed to adopt the role of the perioperative physician. It is naïve to assume that any speciality can merely adopt this role immediately, but it is the combination of pre-existing skills with the uptake of new learning that will facilitate this transition. Although perioperative medicine is perhaps in its infancy, the educational drive behind it certainly is not. The annual Evidence Based Perioperative Medicine (EBPOM) Conference and the ***Perioperative Medicine*** journal are now accompanied by a Postgraduate Masters programme in Perioperative Medicine, all of which highlight a conscious intent to establish this new model of perioperative care. This has been complimented by the Royal College of Anaesthetists recognising its importance, with a view to incorporating it within anaesthetic training [12].

The Royal College of Surgeons of England has highlighted the concerns surrounding the high-risk surgical patient [3]. Perioperative Medicine represents a possible solution through a coordinated and collaborative approach between specialities and, importantly, the patient. As surgical specialties continue to explore new frontiers in older and sicker patients, there is a real need to evolve a perioperative model of care that will support these successes and, as a result, improve outcomes for patients.

References

[1] **NCEPOD**
Perioperative Care: Knowing the Risk Report (2011)
http://www.ncepod.org.uk/2011poc.htm
(accessed April 2014)

[2] **NCEPOD**
Elective & Emergency Surgery in the Elderly: An Age Old Problem (2010)
http://www.ncepod.org.uk/2010eese.htm
(accessed April 2014)

[3] **The Royal College of Surgeons of England and Department of Health Working Group on Peri-operative Care of the Higher Risk General Surgical Patient**
The Higher Risk General Surgical Patient: Towards improved Care for a forgotten group
RCSEng - Professional Standards and Regulation; 2011
http://www.rcseng.ac.uk/publications/docs/higher-risk-surgical-patient
(accessed April 2014)

[4] **Silber J H, Williams S V, Krakauer H, et al**
Hospital and patient characteristics associated with death after surgery. A study of adverse occurrence and failure to rescue
Med Care 1992;30:615– 629

[5] **Pearse R M, Harrison D A, James P, Watson D, Hinds C, Rhodes A, Grounds R M and Bennett E D**
Identification and characterisation of the high-risk surgical population in the United Kingdom
Critical Care 2006;10:R81

[6] **Pearse R M, Moreno R P, Bauer P, et al**
European Surgical Outcomes Study (EuSOS) group for the Trials groups of the European Society of Intensive Care Medicine and the European Society of Anaesthesiology
Mortality after surgery in Europe: a 7 day cohort study
Lancet. 2012; 380: 1059-1065

[7] **Moonesinghe S R, Mythen M G, Grocott M P**
High-risk surgery: epidemiology and outcomes
Anesth Analg 2011;112(4):891-901

[8] **Older P**
Anaerobic threshold; is it a magic number to determine fitness for surgery?
Perioperative Medicine 2013;2:2

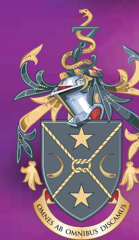
[9] **Department of Health**
Equity and Excellence: Liberating the NHS
London: DoH; 2010
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353
(accessed April 2014)

[10] **Department of Health**
Liberating the NHS: No decision about me, without me
London: DoH; 2012
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216980/Liberating-the-NHS-No-decision-about-me-without-me-Government-response.pdf
(accessed April 2014)

[11] **Health and Social Care Information Centre**
Patient Reported Outcome Measures
http://www.hscic.gov.uk/proms
(accessed April 2014)

[12] **The Royal College of Anesthetists**
Perioperative Medicine – The Pathway to better surgical care
https://www.rcoa.ac.uk/taxonomy/term/683

CAVENDISH MEDICAL



ASGBI
Losing your award FAQs
June 2015

ACCEA awards have been increasingly more difficult to come by in recent years, with the number of new awards being cut along with the introduction of a much stricter renewal process for existing awards.

There is an increasing number of existing awards that are not being renewed, and the consequences of this can be of huge importance both from a financial and pension perspective. Previously, if an award was lost 'pay protection' would mean that the individual would still be paid at the same level. However, pay protection was abolished in March 2015, meaning if an award is lost the individual loses all awards and their pay for CEA points drops to zero.

For example, a national bronze award is currently worth £35,484 gross per annum. If this was not renewed the individual does not revert to a local level 8 with pay of £29,570 gross per annum. They lose the full £35,484 for the national bronze.

This would have a major impact on the vast majority of individuals, but there is an added sting in the tail. Currently, CEA awards are pensionable so count towards total pensionable pay each year. If an award is lost, the individual runs the risk of a significant reduction in pensionable pay which would have financial consequences for their life and the life of their spouse.

A simplified example would be as follows:

- A consultant in the 1995 section of the NHS scheme retires at age 60 with service of 35 years in the scheme and a pensionable pay of £140,000 (inc. his national bronze). This would entitle him to a standard pension of £61,250 gross per annum and a pension commencement lump sum of £183,750. The consultant dies while in receipt of the pension and his spouse then receives up to £30,625 gross per annum for the remainder of her life.
- His colleague with whom he went to medical school is also retiring this year. He used to have a bronze award but lost this when he was age 55. He also has 35 years' service, but his pensionable salary dropped to £104,000 after the bronze was lost. As the bronze award was lost more than three years ago (i.e. did not fall within his best of the last 3 years' salary definition) his standard pension is £45,500 and a pension commencement lump sum of £136,500. The consultant dies while in receipt of the pension and his spouse then receives up to £22,750 gross per annum for the remainder of her life.

The important point to note here is that if an award is lost it may still be counted within the pensionable pay for the next three years so planning is critical should the worst happen. The rules are slightly different for those in the NHS 2008 scheme and in the USS scheme.

In addition to the above, some individuals may qualify for 'step-down' which would protect the higher pensionable pay for pension purposes up to the point the award was lost.

Each situation is different, and will be down to the individual's circumstances. If an award is lost and you are unsure of your options it is important to seek independent financial advice sooner rather than later.

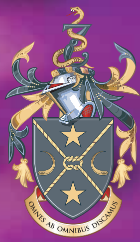
For more information please contact specialist financial planners Cavendish Medical on 0207 636 7006 or visit

www.cavendishmedical.com

The content of this article is for information only and must not be considered as financial advice. Cavendish Medical always recommends that you seek independent financial advice before making any financial decisions.

Levels, bases of and reliefs from taxation may be subject to change and their value depends on the individual circumstances of the investor. The value of investments and the income from them can fluctuate and investors may get back less than the amount invested.

Cavendish Medical



Cavendish Medical

ASGBI
Annual Allowance FAQs
June 2015

GENERAL

What is the Annual Allowance?

- The Annual Allowance was introduced in April 2006 as part of the Government's "pension simplification" legislation.
- It is a limit to the total amount of contributions that can be paid to a pension scheme each year on which income tax relief will be available.

What is included in the Annual Allowance calculation?

- Any contributions to private pensions.
- Any contributions to AVCs.
- Any benefits built up with defined benefits schemes such as the NHS and USS.

What is the current allowance?

- The current allowance is £40,000 in total. This was reduced from £50,000 in April 2014.
- The Annual Allowance has been as high as £255,000 in the recent past.

I am a member of the NHS/USS scheme. How do I calculate how much my benefits have increased by?

- This is a complex calculation and depends on various factors such as inflation, working hours (i.e. full time/part time) and if pensionable salary has changed over the year in question and in previous years.
- The test measures the overall accrued benefits at the start of the 'input period' and again at the end of the 'input period' with an allowance for inflation built in. The difference is known as your Annual Allowance 'input'.

What is the input period for the NHS & USS schemes?

- The increase in benefits is measured between April 1st in one year and March 31st the following year.

What might cause me to breach the Annual Allowance?

- Any private pension/AVC contributions (excluding added years) are taken at their gross value. For example, if you paid £10,000 gross into your private pension this would be the input.
- For the NHS/USS scheme variables are inflation, your service history and your pensionable salary. The effect each has on your input is as follows:
- Inflation is measured as the published CPI rate from the preceding September (1.2% for the 2015/16 tax year). A high inflation rate means benefits can go up by more each year before you breach the allowance. Conversely, a low inflation rate means there is a higher chance of a breach.
- If you are an active member your service will increase each year. A full time member (10 PAs) of the 1995 section of the NHS scheme and current USS scheme accrues an 80th each year. If added years are being purchased, these are added on top of the standard service. If you are on less than full time / 10 PAs the accrued service will reduce.
- If your pensionable salary increases, your benefits will increase as a result, leading to a higher input. Things that may increase your pensionable salary are reaching the next increment of the consultant contract, new local or national CEAs or taking on a pensionable management position. In previous years statutory pay rises have also increased pensionable pay although these are currently frozen.

How can I find out what my Annual Allowance inputs are?

- At the end of each input period your NHS or USS scheme administrator calculates the inputs.
- If you have breached the Annual Allowance they need to write to you by October of that year to inform you of the breach.
- You should be able to find out historic inputs by writing to your scheme administrator.

NB:

- Your input period in the NHS scheme runs from the end of March to the following April and your input notification may only be received in October. This is after the end of the input period and means that you will have no opportunity to amend your behaviour in the input year.

Pay rises that may breach the Annual Allowance

- A 1% statutory pay rise could cause an individual to breach the current £40,000 allowance if they had 15-20 years of service and a high pensionable salary (~£175,000 and above).

- A 2% pay rise would cause a breach of the current £40,000 allowance for most individuals with pensionable salaries of more than £150,000 per annum.

- A 3% pay rise would cause a breach of the current £40,000 allowance for most individuals with at least 20 years' service and a pensionable salary of at least £125,000.

Real life examples:

- A consultant with 20 years' service and a pensionable salary of just under £100,000 moves from threshold 5 to 6 on the consultant contract and also receives a new local point moving from 4 to 5 points. This causes an increase in pensionable pay of £8,553. This increase would cause an Annual Allowance input of over £60,000 in the current tax year.

- A senior consultant receives a silver award having previously held a bronze. At the start of the input period she has 32 years' service within the scheme and before the silver award her pensionable salary was £133,000. The silver award causes an increase in pensionable pay of £11,160 which would give an Annual Allowance input of over £106,000 in the current tax year.

What happens if I breach the allowance in any one year?

- Your NHS or USS scheme administrator should write to you if you breach the allowance and will outline your options.

- If you have breached you have the ability to carry forward any unused allowance from the three previous tax years to help offset the excess in the current tax year.

- If an excess still exists after all carry forward allowances, this excess is added to your income for the tax year and your highest marginal rate of tax is applied. This could mean up to 45% tax on the excess for most doctors.

How do I pay the tax?

- If you have a tax bill to pay this can be dealt with either through amending your self-assessment tax return from the previous year or through "scheme pay" (where the particular scheme allows this facility).

- Scheme pay is where your scheme pays the tax bill to HMRC on your behalf and they then set this against your future pension benefits as a 'debt' which increases with interest until retirement. They then claw back the debt via a reduction in pension benefits at retirement.

Summary

- The Annual Allowance and its interaction with the NHS & USS schemes is complex and will be different depending on each individual's particular circumstances.

- What is right for one person here may not necessarily be right for another, so it is important you understand all of your options before making any final decisions.

- If individuals are unsure of the rules or how they are affected they should seek independent financial advice.

Notes:

- It is important to check the input periods of any private pensions you may have, as the dates may differ from the NHS/USS scheme.

- Your accrual rate will differ depending upon which section of the NHS scheme you are a member of (1995/2008/2015).

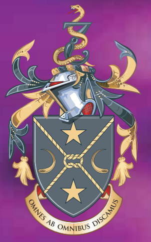
- All figures given on this summary should be used for illustrative purposes only.

For more information please contact specialist financial planners Cavendish Medical on 0207 636 7006 or visit

www.cavendishmedical.com

The content of this article is for information only and must not be considered as financial advice. Cavendish Medical always recommends that you seek independent financial advice before making any financial decisions.

Levels, bases of and reliefs from taxation may be subject to change and their value depends on the individual circumstances of the investor. The value of investments and the income from them can fluctuate and investors may get back less than the amount invested.



coress

A confidential reporting system for surgery

2005 - 2015

CORESS

10th ANNIVERSARY SUPPLEMENT

CORESS IS TEN YEARS OLD!

On Monday 9th May 2005, in the Association's Moynihan Room, the inaugural meeting took place of a 'Steering Group' formed to consider whether surgery in the UK and Ireland could develop a confidential reporting system to mirror that of the Confidential Human Factors Incident Reporting Programme (CHIRP) for aviation and the Confidential Hazardous Incident Reporting Programme for the maritime industries.

A wide-ranging representative group from across all surgical disciplines had been brought together by the vision and enthusiasm of Denis Wilkins the, then, Vice President of ASGBI, who had already come up with a proposed name - '***Confidential Reporting System in Surgery (CORESS)***' - which was to stick.

The embryonic CORESS Steering Group noted that the CHIRP Programme had the following features:

- That CHIRP was complementary to other reporting systems within aviation.
- That it was successful.
- That one of its purposes was to facilitate the reporting of safety related information by individuals directly involved with operating the system.
- That it permitted errors/deficiencies/near misses to be recorded without attachment of blame, and that in turn this provided a mechanism for non-attributable safety information to be fed back to individuals and organisations.
- That the reporter's identity was totally confidential; only the information and subsequent learning was promulgated.
- That CHIRP had an Advisory Board, which reviewed reports, provided advice on action to be taken, reviewed final drafts, reviewed information disseminated to management groups and provided feedback to the Trustees on the effectiveness of the Programme.

It was agreed that such a process could be replicated within surgery, and that CORESS should be formed, by ASGBI, with the following purposes:

- To contribute to patient safety by the Education of Surgeons and their teams.
- To complement other safety systems in the health service.
- In due course, to construct a database that will help to inform quality, training, risk and human factors.

The Steering Group agreed that these were worthy aims, and that the power of any such confidential reporting system would be in its adoption by all associations and societies across all surgical specialties. Thus, CORESS was formed and, in 2015, is thus celebrating its tenth anniversary.

The last ten years have seen CORESS come of age. CORESS is now a recognised independent charity, introduced by NHS Medical Director, Sir Bruce Keogh, at its inauguration at the House of Lords in 2010. Since then, Mr Denis Wilkins has continued to contribute significantly to advancing the cause of surgical safety, and other key figures in CORESS's development include Mr Adam Lewis, the first Programme Director, who devised the original format of CORESS reports as bite-sized vignettes, edited into a readable and consistent style, and Mr Peter Tait, past-Chief Executive of CHIRP, who has been a source of invaluable advice on aspects of confidential reporting. Viscount (Robin) Bridgeman, the founding Chairman of the Board of Trustees, ensured that the fledgling programme had credibility and exposure from the start. Viscount Bridgeman also ensured that a new word, "disidentified", coined by CORESS to explain the process of editing out any information which could reveal the patient, clinician or Trust, was quoted in The House of Lords and recorded in ***Hansard***!

Also, our sincere thanks are due to the members of the Board of Trustees and Advisory Committee (listed below), who provide their time and expertise to ensure that reports are comprehensively reviewed and whose commentary ensures that the lessons to be learned from individual events are credible and authoritative. Nick Gair and the ASGBI office team continue to provide efficient administration support on a shoestring budget, and we are eternally grateful to the Association's President and Executive Board of Directors for their continued support.

Recognition of CORESS's significant role in contributing to surgical safety in the UK is evidenced by involvement of the organisation in safety initiatives such as NHS England's Surgical Patient Safety Expert Group; the Never Events Task Force Report 2014; NHS England National Safety Standards for Invasive Procedures (NatSSIPs); The Royal College of Surgeons of England Patient Safety Bulletin; and the written evidence submitted by ASGBI and CORESS, to the Parliamentary Public Administration Select Committee: NHS Complaints and Clinical Failure in Hospitals Inquiry, which is reproduced later in this edition of ***JASGBI***.

Trends in submitted reports reflect changes in surgical practice in the UK. Perennial concerns persist with respect, for instance, to checking drugs used in surgical

procedures, kit failures, situational awareness and diathermy problems. Evolution of surgical techniques has resulted in increasing numbers of reports reflecting problems in minimally invasive procedures.

Perhaps the most worrying emerging theme however, is adverse incidents arising out of communication failures, as shift systems, poor handovers in ever larger surgical units, and failure of individual surgeons to take responsibility for continuity of patients' care, take their toll. This aspect of patient safety requires constant vigilance and lessons learned from reported incidents need to be widely disseminated. However, as CORESS enters the next ten years, when we hope to see fewer reported adverse events, we anticipate that the importance of senior decision-making earlier in the patients care should become the norm.

Our final thanks go to the reporters, those clinicians who take time to send a report to CORESS, however brief, ensuring that their experience of a near miss or adverse incident may help another surgeon to avoid a similar situation in the future. Over 200 feedback reports have been published in the literature since 2005, and, in this respect, we are delighted that this '10th Anniversary Supplement' contains a bumper edition of reports!

Lord Ribeiro, CBE
Chairman
and
Professor Frank C T Smith
CORESS Programme Director

CORESS ADVISORY COMMITTEE

Mr Stephen Clark
Society of Cardiothoracic Surgeons of Great Britain and Ireland

Dr Tom Clutton-Brock
Royal College of Anaesthetists

Professor Saroj Das
Society of Academic and Research Surgery

Mr Michael Davidson
British Association of Oral and Maxillofacial Surgeons

Mr David Drake
Royal College of Surgeons of England

Mr Luke Evans
SAS and Specialty Doctor Grades

Mr Paul J Gibbs
British Transplant Society

Mr Grey Giddins
British Orthapeadic Association

Mr Mervyn Griffiths
British Association of Paediatric Surgeons

Mr William Harkness
Society of British Neurological Surgeons

Miss Claire Hopkins
ENT-UK

Professor James Hutchison
Royal College of Surgeons of Edinburgh

Professor Narinder Kapur
Imperial College NHS Trust

Professor Zygmunt Krukowski
British Association of Endocrine and Thryoid Surgeons

Mr Martin Kurzer
British Hernia Society

Mr Mike McKirdy
Association of Breast Surgery

Mr Mark Vipond
Association of Laparoscopic Surgery

Mr Richard Novell
Association of Coloproctology of Great Britain and Ireland

Mr Andrew Beamish
Association of Surgeons in Training (ASiT)

Ms Hazel Trender
Vascular Nurse, Sheffield

Professor Peter McCulloch
Clinical Human Factors Group

Dr Lauren Morgan
Clinical Human Factors Group

Dr Gerard Panting
Surgical Indemnity Scheme

Dr Michael Powers, QC
Legal Advisor

Dr Mike Roddis
Healthcare Performance Ltd

Mr David Webster
Deputy Programme Director, CORESS

CORESS BOARD OF TRUSTEES

The Lord Ribeiro, CBE
Chairman

Mr Adam Lewis, CVO
Surgical Member (Past Programme Director)

Miss Clare Marx, CBE
Surgical Member (Royal Colleges)

Mr Denis Wilkins
Surgical Member (Past President, ASGBI)

Mr Andrew May
Surgical Member (Deputy Programme Director)

Mr Peter Tait
Lay Member (Former Chief Executive, CHIRP)

Mr Martin Else
Lay Member (Former Chief Executive, Royal College of Physicians)

Professor Nicholas P Gair
Lay Member (Chief Executive, ASGBI)

Observer Member:
Mr Tom Eke
Royal College of Opthalmologists

In Attendance:
Professor Frank C T Smith
Programme Director, CORESS

ASGBI
Association of Surgeons of Great Britain and Ireland

coress
Confidential Reporting System in Surgery

Written evidence submitted, by the Association of Surgeons of Great Britain and Ireland (ASGBI) and the Confidential Reporting System for Surgery (CORESS), to the Public Administration Select Committee:

NHS COMPLAINTS AND CLINICAL FAILURE IN HOSPITALS INQUIRY

1. Executive Summary

The Association feels that:

- At present there is little in the way of an effective mechanism for systematic learning from serious medical accidents.
- There is a clear need for an effective system which will identify the learning contained in serious medical accidents and use this to bring about change.
- Practices in aviation are similar to those in medicine, and particularly within surgery, to the extent that many of the principles incorporated by aviation could be readily applied to medical practice and would bring about change in the long term.
- That the institution of an investigating body equivalent to the Air Accident Investigation Branch (AAIB) of the Department of Transport would be a major step forward in remedying this deficiency.
- That sporadic enquiries in response to major failures, such as Coroners' Courts, the Bristol Heart Unit and Mid Staffs, although valuable, are an inefficient and traumatic way of bringing about the steady incremental improvement in safety and quality that are the hallmark of properly functioning institutions.
- That the NHS should encourage and support the initiatives of professional independent bodies such as CORESS which have demonstrated their effectiveness in obtaining and disseminating significant learning from precursor events over and above that obtained by statutory bodies.

2. Introduction to ASGBI

2.1 The Association of Surgeons of Great Britain and Ireland is the Speciality Advisory Committee (SAC) defined specialty association for General Surgery, recognised as such by the GMC, the NHS and the Department of Health. ASGBI's umbrella status for the general surgical specialty associations and societies is reflected in the structure of its Council and Committees. The Presidents, or their designated representatives, of the following societies are full members of Council:

- Association of Breast Surgery
- Association of Coloproctology of Great Britain and Ireland
- Association of Laparoscopic Surgeons
- 8 of Upper Gastrointestinal Surgeons of Great Britain and Ireland
- British Association of Endocrine and Thyroid Surgeons
- British Transplantation Society
- Society of Academic and Research Surgery
- Association of Trauma & Military Surgery
- British Hernia Society
- British Association of Day Surgery
- Association of Surgeons in Primary Care

Additionally, Council includes representation from:

- Association of Surgeons in Training
- UEMS Monospecialist Committee in General Surgery

ASGBI is, therefore, the only organisation covering General Surgery and all the specialties throughout the UK and Ireland. We are best placed to reconcile the needs of the developing specialities with the requirement to provide an emergency surgical service.

2.2 At present ASGBI has 1,680 members, all practicing clinicians. We communicate regularly with our membership and produce publications including a quarterly journal (JASGBI) and booklets in our *Issues in Professional Practice* series. These publications are edited by our Chief Executive and Executive Board and recommend best practice relating to a defined surgical or governance issue.

ASGBI runs one International Surgical Congress in the UK per year, as well as a number of Consensus Conferences relating to issues of current concern to

the surgical community.
Details about our work and organisation, including an archive of our publications, can be found at our website:
www.asgbi.org.uk

3. Introduction to CORESS

3.1 The Confidential Reporting System for Surgery (CORESS) is an independent charity, founded by ASGBI, which aims to promote safety in surgical practice in the NHS and the private sector. The charity receives confidential incident reports from surgeons and theatre staff. These confidential reports are analysed by the CORESS Advisory Committee, who make comments and extract lessons from these events. CORESS then publishes these reports alongside the Advisory Committees' safety lessons in the surgical literature to educate fellow surgeons, and to reduce the chances of a similar incident re-occurring in another theatre. CORESS disseminates this information to all interested parties including, where relevant, administration staff, manufacturers, packaging companies, etc.

- CORESS aims to educate, rather than blame, and it serves all surgical disciplines. Some of its key features are:
- Analysing safety-related reports which would not otherwise be available.
- At all times keeping the identity of the reporter confidential.
- Publishing reports widely in surgical literature to educate surgeons and other theatre staff.
- Hosting training courses on safer surgical practice and human factors.

3.2 CORESS has been in existence for ten years and was developed by the then President of ASGBI Mr Denis Wilkins, along with other interested parties. ASGBI continues to be involved in the work of CORESS and the Chief Executive Professor Nicholas Gair sits on both the Board of Trustees and the Advisory Committee.

More information on our Trustees and Advisory Committee, including published 'CORESS Feedback' can be found on our website: www.coress.org.uk/index.htm

4. Reason for Submitting Evidence

4.1 ASGBI and CORESS feel that there is a lack of an adequate system for learning from medical mistakes and effecting change efficiently on a local and national level. We deal with events relating to surgery in a way which we feel would make sense on a larger scale for all medical practice.

5. Submission

5.1 Notification of the request for input was brought to our attention only on the 14th January 2015 i.e. 2 days before the deadline. This response should be seen in that context. If further detail is required we would be happy to provide it.

5.2 The Association is delighted that the Committee is taking the initiative in the matter of learning from error and medical failure and grateful for the opportunity to contribute to its deliberations. The ASGBI has been active in seeking ways to mitigate and learn from surgical error for many years. Its representatives have contributed to many of the professional and regulatory bodies that are focused upon safety and quality issues. These include the Clinical Human Factors Group, NCEPOD, NRLS, SASM and the Patient Safety Committees led by the Surgical Royal Colleges. It has also contributed to enquiries such as the House of Commons Health Committee investigation into Patient Safety 2008-09.

5.3 In 2005 it developed a successful independent reporting and learning system – the Confidential Reporting System for Surgery (CORESS), which now encompasses all the surgical specialties including Ophthalmology.

5.4 It is acknowledged that the NHS has made great strides in the way it collects evidence of medical failing. Trusts have developed well-established mechanisms that include mandatory incident reporting systems. The National Reporting and Learning System (NRLS) of the NPSA has provided a valuable portal through which much in the way of safety related data can be collected and analysed. It appears to CORESS and the Association that the big deficit is the lack of an effective mechanism through which the information gained from such reports can be used systematically to bring about change.

5.5 The Association feels that it is unlikely that a single overarching body can encompass all aspects of learning from medical mishap and failure. For sound reasons, parallels are often drawn between practices in aviation and surgery. The profiles of both – particularly when considering commercial aviation - are uncannily similar. Both require lengthy

and demanding training; the acquisition and maintenance of a complex knowledge base; high order psychomotor skills; a highly professional approach to the discharge of responsibilities; excellent interpersonal/leadership (team) skills and the ability to exercise sound judgement under pressure. Aviation has found it expedient to develop, under the auspices of a single overarching regulator, groups that provide focus on different areas of practice and safety issues. For example, the 'Air Prox' group that analyses collision incidents and risks.

5.6 Often in the face of competing pressures, the commercial pilot must, for example, give absolute priority to passenger safety; a surgeon or physician is required to do the same for his/her patients. Where the two disciplines differ is in the level of uncertainty as to how a patient will react in a given situation. Patients are far less predictable and the working parameters less well defined than for aviation. Nonetheless the similarities between the two professions and the demands placed upon their practitioners are remarkably similar.

5.7 If these similarities are accepted, the question arises as to why the lessons learned and applied in aviation have not been assimilated into medicine to a far greater degree than is presently the case? The answer is that almost from its birth the imperatives set by public outcry and commercial interests have obliged aviation to find and apply effective solutions to catastrophic failures. As a result, commercial flying has become one of the safest, most reliable and cost effective forms of transport across the Globe.

5.8 There are notable initiatives that have demonstrated how aviation practices can be successfully translated into surgical and other areas of clinical practice. The Advanced Trauma and Life Support course was designed by a pilot and has become a mandatory component of postgraduate training in the UK. The World Health Authority (WHO) surgical checklist is a direct copy of the routine flight preparation checklist. The recently introduced re-validation of competence required for continuing practice is also developed from the process of relicensing required for all pilots.

5.9 In retrospect it can be seen that the key organisational change in aviation over the past century has been the evolution of a culture that places passenger safety as the absolute consideration to be applied across all parts of the complex process that is required to deliver safe travel. These include training, engineering, regulation, systems design, air traffic control procedures and flight operations. Overall it is fair to say that having insights into both disciplines and the approaches to safety in each, the Association has been frustrated at the lack of progress being made in surgery – and other medical disciplines - towards identifying and applying the learning from error and its precursors.

5.10 The Association recognises the enormity of the task and respectfully suggests to the PHSO that, as for aviation it will take time, but that it will not be achieved without:

- An independent regulator of the NHS, equivalent to the Civil Aviation Authority (CAA) in the UK and similar bodies elsewhere. This ensures a clear separation of the regulator from the providers.
- A specific body residing within the regulator that is responsible for Patient Safety.
- The input of a number of authoritative, professionally independent bodies, which are competent to analyse error and its precursors; formulate appropriate recommendations and place these into the public domain where they can be used by all concerned and exert maximum influence in bringing about change. We agree absolutely with others, including MaCrae and Vincent in their article in the Journal of the RSM, that the institution of a medical equivalent to the Air Accident Investigation Branch (AAIB) of the Department of Transport, led by a Chief Inspector of Medical Accidents, would be the most important innovation. Others might include the equivalent of the 'Air Prox' Board of the CAA. At present, no such equivalent bodies exist in the NHS.

5.11 It is useful to illustrate the point by including the description provided by the Civil Aviation Authority of its role:

"The Civil Aviation Authority is a public corporation and independent regulator whose work is focused on:
Enhancing aviation safety performance by

pursuing targeted and continuous improvements in systems, culture, processes and capability.

- *Improving choice and value for aviation consumers now and in the future by promoting competitive markets, contributing to consumers' ability to make informed decisions and protecting them where appropriate.*
- *Improving environmental performance through more efficient use of airspace and make an efficient contribution to reducing the aviation industry's environmental impacts.*
- *Ensuring that the CAA is an efficient and effective organisation which meets Better Regulation principles."*

5.12 The Air Accident Investigation Branch (AAIB) of the Board of Transport: Arguably this body and its direct equivalents in Australia and in the USA have done more to enhance safety and bring about system change than any other innovation. It can trace its origins back to the appointment of a Captain Cockburn as the first Investigator of Accidents in the Royal Flying Corps (RFC) and since then it has evolved to its present format.

- There are a number of notable principles incorporated into the way in which the AAIB is set up and operates:
- Its location away from the regulator ensures a suitable degree of independence, which has proved important when it has been necessary to criticise aspects of regulation.
- Its investigators and leaders are current, practicing professionals within the industry, masters of their discipline and selected for their ability to bring a forensic discipline to the investigation of accidents.
- Its investigators have broad ranging powers of investigation that include having overall charge of the incident site and material.
- The continuity of its operation, its experience and the expertise it has built up over the years have proved an outstanding resource.
- Its reports provide the basis for interested parties such as the Regulator, Coroners, Police and others, thereby circumventing the need for separate enquiries by different bodies.

APPENDIX 1

Letter published in the British Medical Journal, February 2011

UK Surgery is already applying aviation practice to improve patient safety

Denis C Wilkins
Trustee, Confidential reporting System in Surgery -CORESS

Dear Sir,

Your correspondents (BMJ Jan 22nd; 342 198-9) appear to be unaware of another example of a system developed by aviation and now adopted by the surgical community. This is the Confidential Reporting System in Surgery (CORESS); the surgical equivalent of the well-established Confidential Human Factors Incident Reporting Programme (CHIRP) in aviation.

Often the only person who recognises a near miss or minor mishap is the one involved. These no-harm incidents or precursors are the vital early warning signs of impending catastrophe (1). It is essential that they are reported and the lessons disseminated and used. If the process of reporting is difficult or there is any concern that confidentiality could be breached with adverse consequences for those concerned, the reporting rate will be low. This was well demonstrated in the US. In 1975 the Federal Aviation Administration introduced the first confidential reporting scheme for aviation; the scheme received very few reports in the first year and led to the management of the programme being transferred to NASA, which was demonstrably independent of the aviation regulator and perceived as an 'honest broker'.

CORESS is independent of the health services. It uses the CHIRP aviation system to operate a portal http://www.coress.org.uk/ through which colleagues and their teams can report secure in the knowledge that the material will be objectively analysed and the lessons disseminated to the surgical community without risk to the reporter or team. The discretion to feed through to the NPSA, information on trends, major hazards and alerts without compromising confidentiality and the trust of its reporters is retained.

We agree that the profession needs to be much more receptive to other areas of aviation practice which have provided answers to challenges not dissimilar to those faced by medicine. Perhaps there is a place for a similar system to CORESS in the medical specialties, for example to do with prescribing error. Outcomes based training has long been the norm in aviation but remains under developed

in medicine. The impact of Human Factors on most aspects of practice has long been recognised in aviation circles but is woefully under recognised by our Health Services, and in our view an independent Medical Accident Investigation Unit operating along the same lines as the superb Air Accident Investigation Agency, could do much to improve our learning from major medical accidents.

Yours faithfully,

Adam Lewis, CORESS Board Member

Frank Smith, CORESS Programme Director and Consultant Surgeon

Peter Tait, Chief Executive, CHIRP & CORESS Board Member

Denis Wilkins, CORESS Board Member

References

(1) Bird Frank E., Germain George L., Loss Control Management: Practical Loss Control Leadership, Revised Edition, Det Norske Veritas (U.S.A.), Inc, Figure 1-3, pp. 5, 1996

APPENDIX 2

Executive Summary of the CORESS *Issues in Professional Practice Publication* (2015) Surgical Quality Assurance (Morbidity and Mortality) Meetings

1. The Inquiry into the problems at the Mid-Staffordshire Hospital demonstrated how the disengagement of clinicians from matters of Clinical Governance and Quality of Care can lead to a catastrophic drop in standards.
2. The Association of Surgeons of Great Britain and Ireland (ASGBI) works with the Surgical Royal Colleges to advise on standards and is concerned to see that long-term solutions to these problems are developed.
3. The Confidential Reporting System in Surgery (CORESS) works independently with a number of specialties to collect cases of surgical mishap and near misses, analyse the causes, and publish regular feedback for the wider surgical community.
4. It became apparent to the two organisations that a better 'grip' by clinical teams on issues of Quality and Safety would be helpful. It had also become clear that the traditional Departmental Morbidity and Mortality Meeting (M & M) is ideally placed to facilitate any changes.
5. This Guide explains how Surgical Departments and their parent Trust hospitals can expand the purposes of the traditional surgical M & M Meeting, to provide a more systematic, timely and comprehensive evaluation of the quality of care being delivered.
6. The Guide makes the following recommendations:
   a. That the Meetings are a fixed commitment and include an expanded range of Quality Indicators relevant to the clinical care, which members deliver.
   b. A Chair is appointed for a fixed period of 1–3 years.
   c. The Role of the Chair includes:
      i. Oversight of preparations;
      ii. Leadership of the Meetings;
      iii. Framing appropriate outcomes and learning points and ensuring that they are disseminated appropriately.
   d. An Administrative Assistant is appointed to collect data and support the Chair and the Meetings.
   e. A comprehensive range of Quality Indicators, in addition to Mortality and Morbidity, are considered during each Meeting cycle. These include incidents, near misses, low harm events, 'Never Events', patient feedback, clinical audit figures for the surgical teams within the Department, etc.
   f. Case presentations should conform to a standard framework – SBAR is recommended.
   g. Learning, outcomes and recommendations from the Meetings should be used for Quality Improvement within the Department and, where appropriate, disseminated via Trust Patient Safety Committees within the Trust.
   h. Time is built into job descriptions by the Trust for the duties of Chair, Administrative Assistant and those required to attend the meetings.
   i. That the title of the Meetings should reflect the enhanced role of the process. 'Surgical Quality Assurance (SQA) Meetings' is suggested.
7. The Guide offers practical advice on how to approach the transition from M & M to Quality Assurance Meetings and also how practical problems during implementation may be addressed.
8. It is hoped that the adoption of these recommendations will help to provide significant improvements in surgical care during the long term. The development of an effective Departmental Quality Assurance and Improvement Platform is seen as an essential prerequisite for monitoring standards, distilling the learning from experience, and using such to bring about evidence-based change where necessary.

coress Feedback

The cases described in this issue of ***Feedback*** emphasise recurrent themes in confidential reporting. Attention is drawn again to the risks of inadvertent diathermy activation. Lack of communication underpins the adverse events recounted in three disparate cases. A case contributed by the ophthalmologists underlines the theme of prevention of retained foreign objects, common to all surgical specialties.

We are grateful to those who have provided the material for these reports. The on-line reporting form is on our website www.coress.org.uk which also includes previous ***Feedback Reports***. Published cases will be acknowledged by a "**Certificate of Contribution**", which may be included in the contributor's record of continuing professional development.

Frank C T Smith
Programme Director, on behalf of the CORESS Advisory Board

LAC OF 'VAC'

(Ref: 185)

A long-stay, complex patient, with a chronic perineal wound being treated with negative pressure dressings, was placed on the emergency list for dressing change, since the patient was unable to tolerate dressing changes on the ward. Higher priority emergencies and reluctance by staff (surgical as well as anaesthetic) to undertake "non-life or limb-saving surgery" in the middle of the night resulted in the patient being deferred for more than two days. It had not been appreciated by the teams involved that a sponge dressing was in-situ without negative pressure being applied, nor had the significance of this been realised. By the time the patient was brought to theatre, there had been deterioration with formation of a large amount of pus. The wound cavity was much more friable and haemorrhagic than previously (whereas it had been slowly improving). As such it was not safe to replace the dressing with negative pressure. This significantly set back the patient's progress.

Reporters Comments:
There was failure to recognise that a negative pressure dressing should not be left without suction for any significant time (let alone two days). Use of the emergency list for patients requiring regular dressing changes may not be appropriate, but is commonplace. There is a need for an alternative to the emergency list for complex patients requiring predictable, regular returns to theatre.

CORESS Comments:
Vacuum dressings are useful in management of open wounds producing large quantities of fluid, but may require specialised management and equipment. Some complex cases may need dressing changes in the theatre environment, particularly if debridement or sedation is necessary. When undertaken in theatre, these cases should be included in an elective schedule rather than on an ad hoc emergency list. Team working practices, in which space is left on a list for urgent ward-based cases, may facilitate this. Good communication at handover between shifts should ensure that a patient's clinical priorities are recognised by the incoming team.

INADVERTENT DIATHERMY ACTIVATION... AGAIN!! *(Ref: 176)*

During an emergency laparotomy, the finger-switch diathermy (which had previously been working normally) stopped working. We checked the lead, connection and machine, and I was told the equipment was functioning correctly. The Mayo operating table partially obscured my view of the diathermy machine. Whilst the circulating nurse fetched another lead, I picked up and used the foot pedal-operated diathermy forceps. It was immediately apparent, on tissue contact, that the forceps were active, even without the foot pedal being depressed. The yellow cutting diathermy pedal had been placed on the base of the operating table. Ten minutes earlier I had asked for the table to be lowered, and the yellow pedal had been compressed between two table components. The volume on the diathermy machine had been turned down to the lowest setting, so no warning signal was audible. Fortunately, the forceps had been in the sheath and not on the drapes or on the patient's skin, and the patient did not come to any harm.

Reporters Comments:
The yellow cutting diathermy pedal is rarely used in my experience and is often placed out of the way to avoid accidental deployment. In this case it was inadvertently depressed and activated when the table was lowered. The diathermy warning volume had been turned down to zero. It was not noticed on the display that the cutting diathermy had been activated.

CORESS Comments:
This is a perennial problem (See CORESS cases 149 & 161, December 2013). Almost all surgeons on the CORESS Advisory Board, across the range of surgical specialties, had been involved in similar incidents. Education about the risks of diathermy is a fundamental component of surgical training and is taught in the Basic Surgical Skills Course and included in the ISCP curriculum.

When not in use, the diathermy pedals should be kept well out of the way of the operating surgeon and not placed above or below the foot of the operating table. The diathermy alarm is there for a purpose and any activation-warning alarm should not be turned off or set to an inaudible level. CORESS has queried the need for an "alarm-off mode". Never leave diathermy forceps lying on a patient, and always place in a protective sheath when not in use to avoid inadvertent harm to the patient.

MHRA have developed an educational module on electrosurgery, jointly with the Royal College of Surgeons of England. This useful tool can be found at:

http://www.mhra.gov.uk/ConferencesLearningCentre/LearningCentre/Deviceslearningmodules/Electrosurgery/index.htm

---

RETAINED FOREIGN OBJECTS IN OPHTHALMIC SURGERY *(Ref: 177)*

A 68 year-old patient underwent trabeculectomy, under local anaesthesia, undertaken by an experienced glaucoma surgeon. Sponges soaked in antimetabolite were placed under the conjunctival flap (into the space between Ténon's capsule and the sclera) for three minutes, as per standard practice. At the end of the three minutes, two of the five pieces of sponge could not be retrieved - it was assumed that they had migrated backwards between Ténon's capsule and the sclera. Repeated attempts at removal eventually resulted in significant orbital hemorrhage. The sponges were eventually removed by an orbital surgeon under general anaesthesia: one was found behind the macula, and the other had migrated to the tendon sheath of one of the rectus muscles. Thankfully, no harm came to the patient's vision.

Reporters & CORESS Comments:
The capsule of Ténon (bulbar sheath) is a thin membrane which envelops the eyeball from the optic nerve to the limbus, separating it from the orbital fat. Local anaesthetic may be instilled into the space between Tenon's capsule and the sclera to provide anaesthesia for eye surgery. A sponge or other item inserted into this space can potentially migrate within the space, to any location beneath the membrane. Standard practice was to insert sponges into the sub-Tenon's space, with no failsafe method of retrieving them. Attempted retrieval (e.g. with forceps) may inadvertently push the sponges deeper.

This problem can be prevented by threading sponges onto a suture (6/0 or 5/0 nylon) beforehand and tying it in a loop, analogous to a necklace. This makes surgery quicker as well as safer. Sponges can still potentially come off the necklace, so they must be counted in and out of the eye. Reconciliation of a swab count is essential in all surgical fields to reduce risk of patient harm.

COMMUNICATION FAILURE COMPOUNDING INAPPROPRIATE DEVICE USE

(Ref: 145)

A 77 year-old man underwent open repair of a 6.5cm infrarenal abdominal aortic aneurysm. Surgery was uneventful; the inferior mesenteric artery was oversewn at the aneurysm sac and a Dacron® bifurcated graft was inlaid to the iliac artery bifurcation on each side. On completion of surgery, the bowel appeared pink and the patient was transferred to the ITU. However, 72 hours after surgery the patient was unwell with elevated CRP and WCC. No other source of sepsis could be identified and a flexible sigmoidoscopy suggested distal colonic ischaemia. The patient returned to theatre for re-look laparotomy where it was found that the distal descending and sigmoid colon had infarcted. A Hartmann's procedure was undertaken, resecting ischaemic bowel, stapling the rectal stump and bringing out proximal descending colon as an end-colostomy in the left iliac fossa. The patient returned to the ITU.

Despite resuscitation, the patient continued to deteriorate and abdominal ultrasound suggested the presence of a pelvic abscess. 72 hours after the second laparotomy the patient returned to theatre for a third time where it was noted that ITU staff had inappropriately employed a faecal management system consisting of a large bore catheter with a sealing 45ml balloon, inserted into the rectal stump. No formal protocol for use of this device had been consulted, and product literature indicated that the device should only be used for bedridden or immobilized, incontinent patients with liquid or semi-liquid stool, to divert faecal matter, protecting wounds from faecal contamination and to reduce risk of skin breakdown and spread of infection.

At the second re-look laparotomy it was found the rectal stump had been disrupted and was communicating with the abscess, which was drained. Since small bowel was adherent to the abscess cavity, requiring extensive mobilisation, and there was now apparent ischaemia of the end-colostomy, the remaining colon was resected, an end-ileostomy fashioned and the rectal stump debrided and re-closed with sutures. The patient returned to the ITU where he made a prolonged and stormy recovery.

Reporters Comments:

Left colonic ischaemia is a recognised complication of aortic aneurysm repair in which the inferior mesenteric artery is usually oversewn. This may occur where the marginal communicating branch of the left colic artery "the wandering artery of Drummond", which forms an anastomosis between the superior and inferior mesenteric arteries is inadequate or diseased. If ischaemia of the left colon is recognised at the time of surgery, the inferior mesenteric artery origin may be inlaid into the aortic graft. Frequently, however, the colon appears normal on completion of surgery. Failure of a patient to thrive postoperatively should always give rise to concern over the possibility of colonic ischaemia.

Inappropriate use of the faecal management system and balloon promoted further ischaemia and disruption of the rectal stump. ITU staff did not liaise with the surgical team and appeared unaware of the nature of the second surgical procedure. No protocol or guidelines were in existence concerning use of the catheter-based system. Product guidelines specifically advise against use in cases of rectal injury. Excessive faeculent discharge would not be expected from a rectal stump. Use of similar systems should only take place in accordance with product instructions and with recognition of potential complications arising from use.

CORESS Comments:

The Advisory Committee agreed with the reporter's comments. The use of the balloon system was clearly

inappropriate in this case. The responsibility for who looks after the patient admitted to the ITU must be clearly established. No matter which clinician holds overriding responsibility, it is vital that adequate communication takes between all teams involved so that the implications of any management strategy are fully understood. Good communication might have prevented the secondary iatrogenic consequences of this known complication of aneurysm repair.

WATER UNDER THE BRIDGE: MISSED DETERIORATING RENAL FUNCTION

(Ref: 186)

An elderly lady with acute arm ischaemia was referred by the on-call surgical SpR in a peripheral hospital, to the Vascular Consultant in the hospital covering the region's vascular take. He informed the Consultant that the patient was in atrial fibrillation, had COPD and IHD. That she also had chronic renal disease was overlooked in the verbal referral. A contrast CT angiogram was undertaken confirming brachial artery occlusion and the patient was then transferred to the vascular centre, arriving late at night. On arrival, the arm was noted to be viable, blood tests were undertaken and a heparin infusion was commenced. A ward round was undertaken next morning before the blood test results were available. In view of the fact the patient had significant comorbidities but the arm was asymptomatic and viable (although with no radial pulse), it was decided to manage her conservatively. The Consultant then handed the patient over to the new Vascular Consultant on-call for that day by telephone, without information about renal function. It was not recognised until late morning that the patient had poor urine output overnight, becoming anuric after the morning ward round. When nursing staff pointed this out to the surgical SHO, it was recognised that the patient had high serum creatinine and urea, with increasing serum potassium. Attempts were made to manage the patient's acute renal failure, but she deteriorated rapidly and died within 24 hours from a cardiorespiratory arrest.

Reporters Comments:

A series of errors predisposed to an adverse outcome in this case. The salient fact, that the patient had severe kidney disease, was inadvertently neglected by the referring SpR. The consultant requested a contrast CT scan, which probably induced acute-on-chronic renal failure. The patient arrived in hospital late at night and the clinical focus was on the presenting complaint of arm ischaemia such that the patient's renal function was overlooked. On review of the patient the following morning blood tests were not yet available and the surgical team were falsely reassured by the relatively good condition of the arm, missing the poor urine output. In subsequent handover, again, the deteriorating renal function was missed.

CORESS Comments:

When investigations are requested, these should always be followed up at the first opportunity. In a vascular patient for whom a contrast investigation is ordered, confirmation of normal renal function should always be checked prior to administration of contrast. With increasing specialisation within surgery, there is risk of the clinician becoming blinkered, concentrating solely on the specialist aspect of the clinical problem. This is poor medicine. A good doctor will always review the patient in context, remaining alert for likely comorbidities. There is evidence that missed deteriorating renal function in elderly patients is a significant problem within the NHS, particularly at night and during weekends. Surgical teams should remain alert to this possibility.

LATE DIAGNOSIS OF RUPTURED ECTOPIC PREGNANCY

(Ref: 153)

As the general surgery registrar, I was called to the Emergency Department by the on-call orthopaedic Senior House Officer (SHO) covering gynaecology and orthopaedics, to see a 38 year-old woman with a positive pregnancy test and lower abdominal pain. I was told that the patient was haemodynamically stable. The SHO had discussed the patient with the on-call gynaecology consultant who had requested surgical review to rule out appendicitis before seeing the patient.

When I saw the patient at 02.30hrs she was in a side room in the Minors section of the Emergency Department, with a blood pressure of 50/38. She had no IV access and was pale and dizzy, having been admitted at 21.00hrs. Since admission she had experienced lower abdominal pain, distention and a number of syncopal episodes. I immediately transferred her to the resuscitation bay, gained IV access, administered fluids, cross-matched 4 units of blood and inserted a catheter. Her blood pressure transiently recovered to a systolic pressure of 117mmHg before falling to around 70mmHg, with a tachycardia of 90-150 bpm. I contacted the gynaecology SHO and asked him to see the patient and to discuss her with his consultant. The gynaecology consultant eventually attended and obtained consent from the patient for emergency laparotomy, subsequently undertaking a right salpingectomy for ruptured ectopic pregnancy. The patient had 5 litres of blood in her pelvis. Postoperatively she made an uncomplicated recovery.

Reporters Comments:

The covering SHO had not been trained in cross-specialty cover and failed to recognise a critically unwell patient with clinical signs of a classical gynaecological emergency. ED staff also neglected to flag up grossly abnormal observations to other medical staff. Trainees covering specialties other than their own, in an on-call capacity should be given adequate training in advance.

CORESS Comments:

With the introduction of shift systems, inadequate exposure of trainees to emergency cases, and reduced staffing at nights, specialty cross-cover in hospitals may become dysfunctional. The patient in this case presented with classical progressive signs of hypovolaemic shock, and symptoms which should have alerted admitting clinicians to the possible diagnosis of ruptured ectopic pregnancy. A concomitant feature of this report is the element of patient “ping-pong”, in which no senior clinician, including Emergency Department staff, appeared to take responsibility for the patient until she had significantly deteriorated. Adequate training and induction for trainees cross-covering other specialties should be provided by Trusts, together with clear mechanisms of expediting senior review for prioritised cases. The Association of Surgeons in Training (ASiT) has published ***Consensus Recommendations on Emergency Cross-Cover of Surgical Specialties*** [1], and reports significant demand for their recently convened courses on cross-cover emergencies, see; www.asit.org/events/courses/ECC

[1] **Emergency cross-cover of surgical specialties: Consensus recommendations by the Association of Surgeons in Training**

International Journal of Surgery (2013); 11: 584-588

“BEAR TRAP” BITES BACK

(Ref: 182)

A young woman was admitted electively for endoscopy and fitting of an 'over the scope' clip (OTSC) to manage a leaking percutaneous gastrostomy site, under the care of a gastroenterology team. An experienced registrar performed the procedure, and the clip was deployed under direct vision. However, upon trying to remove the endoscope it became stuck, seemingly at the upper oesophagus. The endoscope was advanced into the stomach again and it was noted that the clip had deployed onto the scope rather than in a forward

direction onto the PEG site as intended. A consultant took over the procedure, but was unable to dislodge the clip from the endoscope or to remove the endoscope. A second endoscope was passed and the complication was confirmed. The general surgeon on-call was summoned and performed an upper midline laparotomy to remove the clip. The endoscope could only be removed by cutting the end off with a hacksaw and cutters. The ENT surgeon on-call attended to assess the oesophagus and found a deep laceration in the cricopharyngeus muscle. The oesophageal laceration was managed conservatively and the patient recovered after an extended hospital stay.

Reporters Comments:
This was an equipment malfunction. None of the team had previously encountered this complication before. In using OTSCs for the management of enterocutaneous fistulae, the complication of deployment onto the endoscope can occur.

CORESS Comments:
The OTSC is a clip made of shape-memory nitinol alloy, used to close fistulae, perforations, anastomotic leaks, and to seal bleeding GI tract vessels [1, 2]. The clip is mounted onto a silicone cap (similar to a band ligation device), placed onto the tip of an endoscope, and applied by stretching a wire by means of a hand-wheel installed on the entrance of the endoscopic working channel. When the clip is released from the applicator, it closes because of the "shape-memory" effect and the high elasticity of the nitinol alloy, occluding the defect. This is similar to a "bear-trap" closure mechanism and applies a permanent force to the tissues. During introduction of the scope, migration (retraction) of the hood can occur [1]. The operator should ensure that appropriate deployment and visualisation of the clip has taken place before the endoscope is withdrawn.

[1] Diagnostic and Therapeutic Endoscopy Volume 2013 (2013), Article ID 381873

http://dx.doi.org/10.1155/2013/381873

[2] Gut 2013;62:A145 doi:10.1136/gutjnl-2013-304907.326

DELAYED MANAGEMENT OF ALKALI INGESTION

(Ref: 192)

As the on-call ENT SpR, I was referred a patient who had ingested a small volume of hydrogen peroxide, by the medical SHO on MAU. He rightly requested I perform a flexible nasendoscopy to assess for upper airway oedema or burns. The patient was stable with no voice change or stridor. Examination was reassuringly unremarkable.

On review of her notes, it became clear that she had been admitted to the hospital many hours previously. She drank the bleach at 3.00pm, attended A&E around 4.00pm, was triaged as urgent, but was seen hours later, in minors by an emergency nurse practitioner. Although it was recognised that she needed admitting, the potential seriousness of the situation was not noted. Information from Toxbase suggested Q-T monitoring, but no ECG was performed. The patient was referred to the medical team for admission, but no one attended A&E to review her. A doctor did not assess her until 2.30am, when she arrived on MAU, and underwent airway assessment and ECG.

Thankfully the patient remained stable, but ingestion of a toxic alkaline substance has potential to cause acute airway compromise and patients need urgent ENT examination in A&E, not 12 hours later. She had been allowed to eat and drink before medical review, despite risk of upper GI perforation. She was discharged the next day after an OGD had been performed. The A&E department was contacted to implement measures to prevent this incident recurring.

Reporters Comments:
Ingestion of alkali is a serious incident and should be treated as a priority. An appropriate member of staff should assess patients correctly triaged as urgent. Specialist review should be sought in department. Airway assessment and ECG is indicated.

CORESS Comments:
Button batteries are another potential cause of caustic injuries to the

oesophagus caused by sodium hydroxide, produced as a result of electrical discharge from the battery. Over the last few years a significant number of these cases have occurred, such that NHS England has issued a Patient Safety Alert (2014), see:

http://www.england.nhs.uk/wp-content/uploads/2014/12/psa-button-batteries.pdf

DAY-CASE HERNIA ANTIBIOTIC ANAPHYLAXIS

(Ref: 194)

A 72-year old patient was admitted for day case repair of a symptomatic right inguinal hernia, under local anaesthetic. Past medical history included total knee replacement for osteoarthritis, severe COPD and home oxygen therapy, with exercise tolerance limited to 15 yards. He had previously been advised not to have a general anaesthetic. In theatre, the patient was monitored and IV access was secured. The surgeon performed an initial ileo-inguinal block with 1% xylocaine with adrenaline, and requested that antibiotic prophylaxis be administered. Co-amoxiclav, (1.2g IV), was administered by the anaesthetist. Within 60 seconds, the patient developed a cough that progressed rapidly to wheeze and then severe shortness of breath with cyanosis. Initial treatment was undertaken with oxygen and salbutamol nebulisers, but the patient rapidly became unresponsive and required intubation and ventilation. He was treated for presumed anaphylactic shock with adrenaline, hydrocortisone, magnesium sulphate and chlorphrenamine. Arterial blood sampling confirmed respiratory failure with an acidosis (on 100% FiO2: pH 7.10; pCO2 11.1; pO2 7.1; O2 saturation 75%; lactate 7.0; bicarbonate 18.2). The operation was abandoned, and the patient was transferred to ITU, where he required an adrenalin infusion overnight. The patient was extubated at 24 hours, returned to the ward, and was discharged within 48 hours, making a full recovery.

In the outpatient clinic, at pre-operative assessment and during the theatre WHO checklist, the patient denied any penicillin allergy. However, careful retrospective review of the patient notes and interviews with family members suggested an episode 12 months previously when the patient was admitted to A&E with a sudden onset of a generalised rash, facial swelling, wheeze and cough after their GP commenced them on amoxicillin for community acquired pneumonia. The symptoms at that time had started immediately after administration of a dose of amoxicillin, and improved with prednisolone and salbutamol. Despite these features, the patient was not warned about the possibility of allergy and did not have any allergy testing, resulting in the patient being ignorant of the condition. Subsequent blood test findings included positive mast cell tryptase and raised IgE post-event. The patient is now aware of his allergy status and wears an alert bracelet.

Reporters Comments:

Patients' knowledge of their medical history can be unreliable. It is advisable to be prepared: IV access is useful whenever a patient is undergoing a significant interventional procedure, even under local anaesthesia. Finally, our interventions are undertaken with good intentions, but as in this case can lead to harm. The current evidence base does not support antibiotic prophylaxis in groin hernia repairs.

CORESS Comments:

The problem here was that there is no clear evidence that it was recognised that the patient had a drug allergy. Phrasing an open question to a patient “have you ever had any adverse reaction to a drug you’ve been given?” may be more useful than a cursory query about drug allergies.

A recent Cochrane meta-analysis [1] showed that there is insufficient data overall to demonstrate a clear advantage of antibiotic prophylaxis in hernia repair, but illustrated a classic problem in evidence-based medicine where a lack of evidence in support of an intervention may be interpreted as a reason not to implement it.

[1] **Sanchez-Manuel F J, Lozano-García J, Seco-Gil J L**

Antibiotic prophylaxis for hernia repair. Cochrane Database Syst Rev. 2012 Feb 15;2:CD003769. doi: 10.1002/14651858.CD003769.pub4. Review.

SLIPPERT DEPARTURE

(Ref: 195)

During routine laparoscopic appendicectomy, during which the operating table was tilted, the patient, a 70kg man, slid to the floor. Laparoscopic instruments were pulled out as the patient fell, but ports remained in situ. The patient was transferred, with full spinal protection back to the operating table, and the procedure completed without further event. There was no intra-abdominal injury as a result of the fall. Postoperatively the patient was taken to the CT scanner for imaging of his head and spine. No injury was apparent. The patient made an uneventful recovery and was discharged two days later.

The incident was debriefed with the theatre team, incident forms were completed, and the matter has been raised at anaesthetic and surgical governance meetings.

Reporters Comments:

Some months before, low friction patient transfer (Slide) sheets had been introduced to move patients to and from the operating table. These sheets were routinely left under patients during surgery and contributed, in this case, to the patient's departure from the table.

After the incident occurred it became apparent that other theatres had had problems with patients moving (but falling short of slipping off the table completely) since introduction of these transfer sheets. We have now changed our operating procedure so that surgical patients are placed either skin-to-mattress (if narrow enough to roll onto and off a transfer sheet) or onto a vacuum bean-bag device (if too wide to be rolled). Slide sheets are removed once the patient is positioned.

CORESS Comments:

There is a team responsibility to ensure safe patient positioning, but the surgeon should include this in his personal safety checks for the patient, prior to commencing any procedure. If an operating table is tipped or inclined, adequate patient restraints in the form of straps or poles should be employed.

INADVERTENT ADMINISTRATION OF MUSCLE RELAXANT

(Ref: 196)

A 45 year-old woman underwent uneventful laparoscopic cholecystectomy for biliary colic. On transfer to the ward, she developed acute respiratory arrest, after her cannula (placed in theatre) was flushed prior to administration of cyclizine for postoperative nausea. She became visibly cyanotic and flaccid, and required emergency ventilation with a bag-valve mask and simple airway manoeuvres, for approximately one minute before regaining the ability to breathe. She subsequently had full recollection of the event, but reported that she was unable to move or breathe. On investigation it transpired that some residual atracurium muscle-relaxant had been present in the triple lumen iv line connector.

Reporters Comments:

The IV line connector was not thoroughly flushed with normal saline after use in theatre, by appropriately trained anaesthetic staff. This was discussed at surgical and anaesthetic governance meetings, which concluded that the use of multiple port connectors should be limited (employing single injection ports instead) and that cannulae and all ports of any intravenous device must be thoroughly flushed after use.

CORESS Comments:

The Advisory Board agreed with the reporter's comments. The NRLS has produced a Signal Alert concerning ***Residual Anaesthetic Drugs in Cannulae*** (2009), see:

http://www.nrls.npsa.nhs.uk/resources/?EntryId45=65333

A FATAL TWIST

(Ref: 187)

A normally fit and well patient presented with a relatively low rectal cancer. Staging scans showed no metastases and clear margins. Following MDT discussion, the patient was admitted for a laparoscopic low anterior resection.

Findings at operation revealed a floppy sigmoid colon. The cancer was below the peritoneal reflection. A standard medial to lateral approach was performed, with high ligation of IMA and IMV. There appeared to be adequate length for the anastomosis, so splenic flexure was not mobilised. The rectum was cross-stapled at the pelvic floor. The patient was then placed flat. A small midline extraction incision was then made at the umbilicus. A wound protector was placed in the incision, the specimen extracted, and excised. The anvil of a CDH circular stapler was secured with a prolene purse string suture and intra-corporeal anastomosis performed. Prior to firing the gun, a visual check of the orientation of the afferent limb of the anastomosis was performed, tracing the cut edge of the mesentery and also the colon itself, to exclude a twist. As the anastomosis was colo-anal, a loop ileostomy was formed in the right iliac fossa.

Post-operative recovery was initially slow with an ileus. CT excluded a leak, and the patient recovered and was discharged home. The patient was subsequently readmitted with renal impairment, due to a high output stoma, which responded quickly to IV fluids. Pathology confirmed a Dukes' A cancer. Given the problems with the stoma, it was decided to reverse this early. The patient was admitted for a routine ileostomy closure. The following day the patient looked well and plans made for fluid and diet, and discharge within a day or two.

Over the next few days the patient developed abdominal distention, pain, melaena and a fever. Bloods showed an elevated CRP and white cell count. The patient was found to be a Cl. Difficile carrier (but toxin negative), causing some confusion initially on the ward as to the significance of this finding. Antibiotics and IV fluids were started on the third post-operative day.

A CT was performed on the 4th post-operative day. Initially this was reported as showing large bowel obstruction but, when reviewed by the surgeon with the radiologists, a twist in the descending colon was identified with proximal obstruction. Following resuscitation the patient was taken to theatre where a necrotic colon was excised and an end-ileostomy formed. Post-operatively, the patient was nursed on the ITU, but unfortunately became more septic and unwell and died the following day.

A thorough review of the circumstances was undertaken. The surgeon routinely checked orientation of the colon prior to anastomosis, by identifying the cut edge of the mesentery and also by following the bowel up the left paracolic gutter. An orientating stitch is also used in the anvil of the gun. All of these were found to be satisfactory in this case. At the subsequent laparotomy, the twist was abrupt and occurred just below the splenic flexure, the view of which was likely to have been obscured by omentum and small bowel loops.

Review of the imaging showed the twist on the "ileus" CT, but it was not picked up at the time. Gastrografin enema was normal with no twist seen to the mid-descending colon. The final CT was not reported as showing the twist, until the swirl of the mesentery and vessels was noted by the operating surgeon and confirmed by the radiologists.

Reporters Comments:
Have a high index of suspicion when patients do not progress as you expect them to post-operatively. Do not withhold antibiotics if a patient

has a clinical picture that cannot be explained by abnormal stool results such as initial tests for Cl. difficile. The Trust is now changing to more reliable and rapid tests, which should eliminate this problem.

Imaging in such patients should be reviewed by both radiologists and surgeons, as there may be aspects of the surgery that the radiologist does not appreciate and pathology may be missed.

Be aware of the risk of rare complications, such as twisting of the afferent limb of the colonic anastomosis, and ensure clear and careful checks are carried out prior to firing the stapler. This surgeon now keeps the patients head down when performing the extraction and excision, and checks orientation immediately after extraction as well as after replacement of the conduit following excision and anvil placement.

CORESS Comments:
The Advisory Board agreed with the reporter's comments.

HANDOVER BLUES

(Ref: 188)

A patient was kept in hospital for pain control after a difficult elective laparoscopic cholecystectomy. On the following morning, a Friday, the patient had an unusual amount of pain, but with normal observations and a tender but non-peritonitic abdomen. Blood tests revealed an unusually high inflammatory response and supportive therapy was organised, with repeat assessment over the weekend. The patient was handed over to the night on-call team for review.

On Saturday morning, the night registrar noted the patient wasn't on the list for ward review (in our hospital, in-patients are placed on a different list from post-take patients and are reviewed by a separate surgical team). The FY1 was informed and asked to place the patient's name on the review list. For whatever reason, the patient's name was not included on this list, and subsequently the patient was not reviewed that day, by the locum registrar covering the wards. The ward nurses responsible for the patient did not alert the surgical team.

On Sunday morning, the night on-call registrar, who knew the patient, coincidentally reviewed the blood test results from Saturday and noted a soaring inflammatory response. The on-call team reviewed the patient and found him septic and with peritonitis. The patient underwent urgent laparotomy, and a sub-hepatic collection of old blood, bile and fibrin was washed out. The patient eventually made a satisfactory recovery.

Reporters Comments:
There was lack of a robust system of handover that could pick up missed referrals from individuals feeding information to the lists. No communication took place between senior doctors about a potentially sick patient. There was also lack of communication between nurses and doctors. The handover system relied exclusively on information manually typed by the most junior member of different teams, and there was no provision in place to cross check information on the handover list, with the electronic patient records our hospital uses.

CORESS Comments:
With the move towards increased teamwork and shifts systems, there is a real risk of loss of patient "ownership", and diminished individual clinician responsibility for patient care. Previous CORESS cases have already illustrated similar problems in communication, particularly during handovers from one shift to the next. Medical staff should review all ward-based surgical patients every day. A standardised early warning system or score, employed by the Trust, might have flagged up that this patient was at increased risk.

MISSED URETERIC OBSTRUCTION

(Ref: 155)

A 25 year-old man was admitted with right iliac fossa pain, associated fever and vomiting. He had a family history of renal calculi. On examination, he was tender in the right iliac fossa and right loin. Urinalysis was strongly positive for microscopic haematuria. CRP was normal, but there was a leucocytosis on full blood count and the serum creatinine was 111 μmol/L. No stones were visible on X-ray KUB. Ultrasound of abdomen and pelvis was performed on day three "to exclude appendicitis or renal pathology". Kidneys were of normal size and appearance bilaterally, with no comment about the ureters. Free fluid was seen in the pelvis. The patient was listed for an appendicectomy on day four, as his fever and pain persisted. Prior to surgery, however, the anaesthetist raised concerns that the creatinine was now 140 μmol/L, despite appropriate fluid administration, and that a CT KUB had not been performed. Surgery was postponed and a CT KUB was undertaken which showed a 5.5mm calculus in the proximal right ureter, causing obstruction and hydroureter. The patient was transferred urgently to the local urology services for stenting. He was discharged the following day with improved renal function.

Reporters Comments:
A strong history and findings suggestive of renal tract pathology were not acted upon, and timely appropriate investigations were not performed. The ultrasound report did not comment on the ureters, despite mention of haematuria on the request form.

CORESS Comments:
This case describes a failure to diagnose ureteric obstruction. The diagnosis of appendicitis was flawed. The patient exhibited a number of symptoms that should have prompted clinicians to carry out a CT KUB, the “gold standard” investigation for renal tract stones, within 24 hours of admission. Patients with haematuria and abdominal pain should be appropriately investigated for renal stones. Worsening renal function despite adequate fluid intake should increase suspicion of underlying renal tract pathology.

THINGS CAN GO WRONG WHEN A PATIENT SAYS ‘YES’

(Ref: 172)

During an ophthalmology outpatient laser clinic, another patient came to my clinic room instead of the patient I had actually called. I think she must have misheard the name that I called out. We discussed the scheduled treatment (laser iridotomy), she signed a consent form with the other patient’s sticker at the top, and I performed YAG laser iridotomies on her. Unfortunately, the patient I treated had been listed for selective laser trabeculoplasty, and so she ended up having the wrong laser procedure. I did not check her date of birth, and the patient had answered “Yes” when I asked her if she was Mrs X. Soon afterwards, I realised what I had done; I immediately told the patient what had happened and notified this event to my Trust as a Serious Untoward Incident. Thankfully, no harm was done.

CORESS Comments:
This case illustrates the dangers of ‘passive’ identification of patients. It is easy for a patient to mishear a question and then inadvertently agree with the clinician. This problem would not have occurred if the clinician had actively followed the principles of the WHO preoperative checklist. The patient should be asked ‘please tell me your name’, with similar open questions asking them to state their date of birth, address, planned procedure and side to be treated. This principle applies to many other situations in medicine and surgery. Positive identification of patient, procedure, and side to be operated on is also vital in many other situations, including ordering and interpretation of tests.

WRONG EYE DROPS ADMINISTERED

(Ref: 211)

Whilst on call, I was treating a patient who presented with angle closure glaucoma. I had to go to the ophthalmic ward to obtain some pilocarpine, and put the minim packet into my pocket. Earlier, I had also collected some atropine. When I came back to instil this medication to the patient, I administered atropine by mistake. I realised the mistake straight away. I washed the eye with saline and then administered pilocarpine. I explained to the patient what had happened and then, with senior support, peripheral iridotomies were performed on the patient. The patient did not come to any harm.

Reporters Comments:

I was distracted by having to leave the patient to go and get the pilocarpine. The packaging of the atropine and pilocarpine were similar, and I failed to check the medication before I administered it.

CORESS Comments:

This case illustrates a number of sources of potential risk. Systems errors occurred in that the drugs required to treat the patient were not available in the patient's location, and were contained in similar packaging. Moreover the reporter was carrying two different types of drug, increasing potential for confusion. CORESS has published details of a number of similar cases in different clinical situations. The bottom line, in all of these cases, is that it is always the duty of the treating clinician to ensure that they have physically checked the drug before administering it to the patient.

COMPLICATION OF GASTRIC BYPASS

(Ref: 210)

I undertook a gastric bypass on a 45 year-old Type II diabetic patient with morbid obesity and BMI of 45kg/m2. The patient had hypertension and was a smoker. During laparoscopic bypass, the patient was noted to have a paraumbilical hernia measuring approximately 5cm at the neck, and containing a plug of omentum. As part of the procedure, the omental plug was reduced to facilitate access to the duodeno-jejunal flexure. The gastric bypass was performed uneventfully. A decision was made not to repair the hernia at the time of surgery, because of the risks of recurrence, and because the open lumen bowel surgery would have increased risks of mesh infection. Four days postoperatively, the patient was admitted with bowel obstruction secondary to small bowel incarceration in the paraumbilical hernia. This had caused local bowel perforation and faecal peritonitis. Despite laparotomy and washout, the patient became critically ill and developed a cascade of complications requiring repeated bowel resections and laparostomy. The patient died two months later from multi-organ failure.

Reporters Comments:

The patient's risks of complications arising from paraumbilical hernia repair were increased because of obesity and comorbid conditions. Hernia repair was therefore deferred. In the event, the patient developed incarceration, leading to bowel perforation and peritonitis. In future, I would be more likely to perform sleeve gastrectomy than gastric bypass, in a patient with a controlled ventral wall hernia, since the latter procedure does not require mobilisation and dissection of the omentum.

CORESS Comments:

The Advisory Board accepted the reporter's decision not to fix the hernia and also noted that it might have been difficult to detect the hernia on examination pre-operatively because of the patient's obesity. An option, however, was to obliterate the potential space laparoscopically, with an omental plug. Use of biological meshes may reduce the risk implications of mesh infection.

TOUGH NUT TO CRACK

(Ref: 197)

An 82 year-old diabetic lady, with non-salvageable leg ischaemia, was admitted to the hub hospital of a vascular network. She was admitted under the on-call consultant, her angiograms reviewed, and care was handed over to the consultant in charge of ward care for the week. The latter consultant arranged for her to be placed in an available slot on an elective operating list, undertaken by a third consultant vascular surgeon.

At surgery, above knee amputation was somewhat protracted by the discovery of the long stem of a hip prosthesis, when dividing the femur. Diamond-tipped power tools eventually enabled division of the femur and prosthesis, and the patient made a satisfactory recovery.

Reporters Comments:
The presence of the hip prosthesis, although noted, was not commented on by the on-call consultant, on handover to the ward consultant, who did not review the angiograms personally and failed to notice the operative scar over the hip. The operating consultant, having had the patient place on his list by his ward-based colleague, also failed to review the films and missed the old hip operation scar.

CORESS Comments:
With modern consultant-delivered team working, shift systems and multiple handovers, there is a risk of important clinical information not being communicated. The responsibility for ensuring patient safety lies with each clinician in the chain and, despite the advent of specialisation, basic surgical tenets of adequate history taking and clinical examination must not be ignored. Although a WHO check was undertaken, the operating surgeon had not personally reviewed the films, which would have indicated the presence of the hip prosthesis. Moreover, a check for metalwork should be undertaken before applying a diathermy plate.

INADVERTENT INJECTION OF CHLORHEXIDINE DURING ANGIOGRAPH

(Ref: 204)

A serious untoward incident, involving inadvertent injection of an alcoholic solution of 2% Chlorhexidine, occurred during a lower limb angiogram. The fluid was drawn up from an unlabelled gallipot, adjacent to the intended X-ray contrast media for injection. The procedure was performed under low lighting. Tissue necrosis developed and amputation of the leg was eventually necessary.

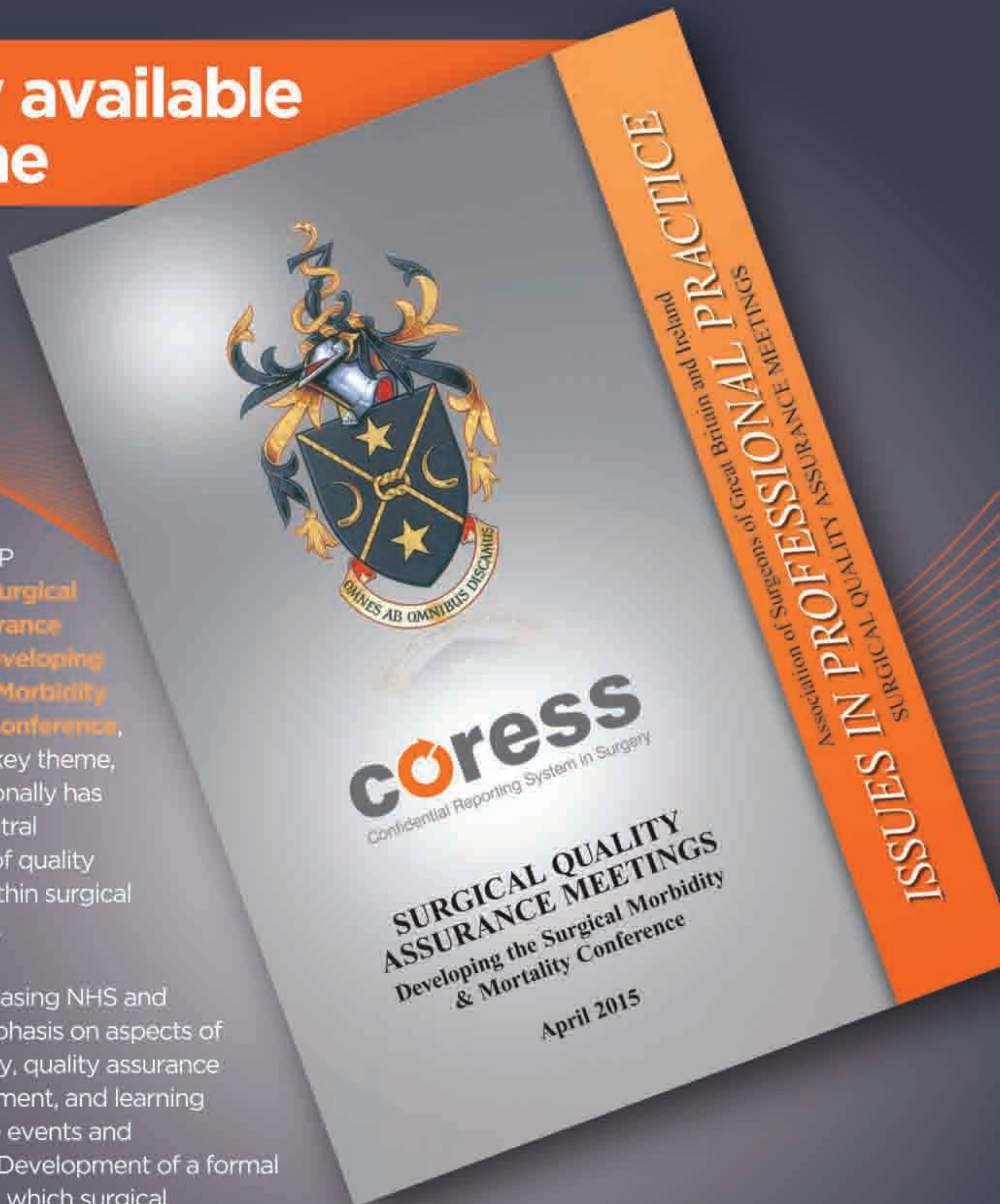
Search of the NRLS database revealed 4 incidents during the last 3 years involving inadvertent IV injection of Chlorhexidine instead of X-ray contrast media. Two caused severe harm, another causing cardiac arrest during a pacemaker insertion. One near miss occurred where there was potential for the syringe intended for IV contrast media to have been refilled from an unlabelled open container filled with Chlorhexidine. In another incident, a patient's arterial line was flushed with Chlorhexidine from a gallipot instead of the intended saline solution.

NPSA has previously drawn attention to similar problems in the Signal: ***Injectable medicines in theatres*** see:

http://www.nrls.npsa.nhs.uk/signals/?entryid45=66753

CORESS / SSPSEG Comments:
This incident was discussed in detail at the Surgical Services Patient Safety Expert Group, who concluded that all skin cleansing agents should be removed from the interventional field prior to commencement of the intended procedure. As a corollary, agents to be injected should be drawn up from labelled sterile containers and must be checked prior to administration.

Now available online



This latest IIPP booklet, on **Surgical Quality Assurance Meetings: Developing the Surgical Morbidity & Mortality Conference**, addresses a key theme, which traditionally has formed a central component of quality assurance within surgical departments.

There is increasing NHS and specialty emphasis on aspects of surgical safety, quality assurance and improvement, and learning from adverse events and near-misses. Development of a formal framework in which surgical departments can actively demonstrate their participation in quality assurance, to interested bodies, and can influence standards of care for surgical patients, has attained increasing importance.

This joint publication between ASGBI and the Confidential Reporting System for Surgery (CORESS) offers a template for refinement of the traditional Morbidity & Mortality Meeting into a more encompassing forum, the Surgical Quality Assurance Meeting, through which surgical departments in NHS Trusts can embrace and develop aspects of safety and quality of care for all surgical patients. The template has pan-specialty relevance and can be employed in all surgical arenas.

www.asgbi.org.uk/publications

Journal of the Association of Surgeons of Great Britain and Ireland

2016 Belfast Surgical Week

The Association's next International Surgical Congress will be held in Belfast from **Wednesday 11th to Friday 13th May 2016** in the brand new Waterfront Centre. The deadline date for the submission of abstracts will be **Midnight on Monday 4th January 2016**. In addition to abstracts submitted for the Moynihan Prize, there will be the following categories of short paper and poster presentations:

- Patient Safety
- Breast/Endocrine
- Hernia/Soft Tissues
- Vascular and Transplant
- Trauma & Military Surgery
- Basic and Applied Clinical Science
- Cancer/Surgical Oncology (GI)
- Perioperative Care/Nutrition
- Minimally Invasive Surgery
- Surgical Complications
- Emergency Surgery
- General
- Clinical Informatics
- Education and Training
- Randomised Clinical Trials
- Audit and Outcomes Research
- Cancer/Surgical Oncology (Other)
- Surgical Simulation and Technology

JASGBI IS PUBLISHED BY

Association of Surgeons of Great Britain and Ireland
35-43 Lincoln's Inn Fields, London, WC2A 3PE
Tel: 020 7973 0300 • Email: admin@asgbi.org.uk • Web: www.asgbi.org.uk
A Company Limited by guarantee, registered in England: 6783090. VAT number: GB 944 3070 34

EDITORIAL BOARD

Director of Communications: Mr David Rew
Editorial Advisors: Mr John Moorehead and Professor Rowan Parks
Production Manager and Publisher: Professor Nicholas P Gair, on behalf of ASGBI Ltd

JASGBI is an educational publication, distributed free to members of the Association.
The opinions expressed in this Journal are those of the individual authors, and do not necessarily reflect the policy of the Association of Surgeons of Great Britain and Ireland.

ASGBI gratefully acknowledges the professional support of the following Corporate Patrons: