



PRESIDENT'S REPORT

Sir Bruce Keogh

The six Society objectives 2006–8:

1. **To finalise the public disclosure of surgical results**
2. **To develop an organisational structure which integrates and recognises the professional requirements of different surgical sub-specialties**
3. **To develop a strategy to maximise employment opportunities for UK trainees**
4. **To develop an innovative approach to patient involvement in the Society**
5. **To develop a specialty driven template for re-accreditation of surgeons**
6. **To develop a mechanism for the Society to develop clinical guidelines**

Over the last few years our Society has been paralysed by the spectre of public disclosure of surgeon-specific results. These have now been published with little, but generally positive, interest from the media and it is now time for us to move on. During this time the socioeconomic platform underpinning the NHS has changed dramatically, improving interventional techniques and primary and secondary prevention strategies in coronary heart disease have begun to erode the staple diet of cardiac surgeons around the world.

Any successful organisation needs to know where it is heading. To maximise its vision it needs to identify, analyse, understand and prioritise prevailing and future internal and external threats and opportunities. It also needs to understand clearly what it can and cannot influence, where it can make inroads and where effort and energy bring the biggest “bang for the buck”.

To help us focus our efforts over the next two years your Executive Committee has



agreed six objectives. It is anticipated that as these are achieved they will roll over and additional objectives will be added to provide organisational focus, continuity and momentum over the years. This is a new approach. We have identified the pressing issues, nominated individuals with portfolio responsibility for the objectives and have redesigned our Executive Committee agenda to focus on and monitor progress against the objectives. We have not yet prioritised the objectives since, in organisational terms, they have all come off the starting blocks at the same time.

Objective 1: To finalise the public disclosure of surgical results

This will be led by James Roxburgh and overseen by the joint Healthcare Commission, SCTS and Department of Health Tripartite Oversight Group. Publication of unit results will be mandatory, publication of surgeons' results remains voluntary and the Healthcare Commission has no inclination to modify this approach. The voluntary nature of the individual surgeons' results reflects discussions at the 2005 ABM where this approach was developed to prevent newspapers pursuing the data and presenting it in a sensational format. To try to reverse this would re-expose us to that same threat and threaten our credibility as a forward thinking and transparent specialty.

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Objective 2: To develop an organisational structure which integrates and recognises the professional requirements of different surgical sub-specialties.

There are currently three major subspecialties represented within SCTS: Adult cardiac surgery, general thoracic surgery and congenital surgery. We are a professional membership organisation and as such we need to offer education, support and leadership to all our members. Observations of organisation around the world indicates that if the balance of organisational energy does not reflect the professional interests of members then certain groups become disheartened and look elsewhere for different, more interesting or better activities and support. Thoracic surgeons have historically felt under-represented in a number of national organisations and I am determined that we consolidate our activities in such a way that general thoracic surgery is on an even footing with cardiac surgery. This is all the more important as trainees and young consultant increasingly focus on developing a holistic cardiothoracic surgical practice. Jim McGuigan is leading a SCTS working group to explore available opportunities in this regard. Increasingly we will also need to focus on offering a professional focus for cardiothoracic nurses. The Forum, currently led by Tara Bartley, has been very successful and we are in discussions with the RCN to seek joint opportunities.

Objective 3: To develop a strategy to maximise employment opportunities for UK trainees.

This is perhaps the most difficult because we don't have the necessary influence to create jobs. However, Chris Munsch, as chairman of the SAC, has played an important role in ensuring that the Deans, Department of Health and trainees are kept fully informed as the panorama unfolds. I will reiterate that trainees must understand that the temporary half decade of reduced competition has evaporated and each and every trainee who wishes to succeed must make himself or herself highly competitive.

Objective 4: To develop an innovative approach to patient involvement in the Society

At the last ABM in Dublin I proposed that we explore including patients as members in the Society. This was predicated on the observation that resolution of many of our political issues over the last few years would have been facilitated by lay involvement. Patients do not want dodgy information, they do not want high risk avoidance, they do not want over tired or poorly trained surgeons and they certainly don't want to see fully trained competent surgeons unemployed in the face of waiting times for surgery. The proposal was met with cautious enthusiasm. Now we have to work out the details. How do we integrate patients in a way that is not patronising, which areas do we need their help, what can we offer them, how do we handle the angry and how do we ensure appropriate representation within the executive structure of the organisation and what are the financial risks and opportunities? Graham Cooper and I have met with Harry Cayton the Patient Czar who has given us some ideas and Graham is considering these issues with the context of the Constitutional Working Group, which he chairs.

Objective 5: To develop a specialty driven template for re-accreditation of surgeons

In 2005 Chief Medical Officer was instructed to undertake a review to:

- Strengthen procedures for assessing the safety of patients in situations where a doctor's performance or conduct pose a risk to patient safety of the effective functioning of services
- Ensure the operation of an effective system of revalidation
- Modify the role, structure and functions of the General Medical Council

On the 14th July he submitted his report "Good Doctors, Safer Patients" to Parliament. Further consultation closed on 10th November, but certain things were clear. There is an appetite to introduce revalidation in some form or another. The onus of undertaking this will fall to the employer but standards will be set by the Royal Colleges and the specialist associations. When this was discussed at the RCSEng Council and subsequently at a meeting of the presidents of the surgical associations this was seen to offer a unique opportunity. There was complete unanimity that professional associations such as ours should be in the business of standard setting. Interestingly, the American Board of Thoracic Surgery has recently been out to consultation on how best to conduct maintenance of certification. The resultant application to the American Board of Medical Specialties has recently been accepted. Their template ticks all the boxes required in the CMO's report so I have been in touch and they would be happy to help where they can. It seems that this offers a unique opportunity for our Society. We have international standards, international on-line journal based CME, we have national data and we are a responsible and responsive specialty. Pat Magee is leading a working group to take this forward. The aim is to present the ABM in 2007 with a proposal for a pilot scheme for specialty based revalidation. The group includes Sir Donald Irvine, past president of the GMC, Dr Angela Coulter, CEO of Picker Europe and Mr Gavin Larner, Head of Implementation, Professional Regulation, for the CMO at the Department of Health. Gavin was previously Head of the Heart Team at the Department of Health and understands our specialty intimately.

Objective 6: To develop a mechanism for the Society to develop clinical guidelines

If we accept that part of the core business of a specialist association should be the promulgation of professional standards, then it is not a giant leap to believe that our Society should be in the business of either developing, endorsing or facilitating dissemination and implementation of guidelines and good practice. This endeavour will be led by Mr Graham Venn and Mr Ben Bridgewater.

So the next couple of years will be a time of great opportunity for the specialty. There will be some turbulence, but under the new executive structures proposed by the Constitution Working Group there is every reason to believe that our vertical integration, communication and involvement of members will improve dramatically. This will greatly enhance our organisational responsiveness and flexibility and enable us to develop a vision for the specialty based on effective leadership and greater consensus with members. ■

WHAT ARE THE BENEFITS OF MEMBERSHIP?

Healthcare is changing and so are the roles of the royal colleges and professional societies. Membership of the SCTS carries financial implications and it is not unreasonable for existing or perspective members to ask what they get from their subscription money. A number of benefits of membership are listed below.

To keep up with developments the SCTS is currently undergoing a fundamental review of its structures and functions (see article by Graham Cooper on the proposed changes to the Executive structure) but what is clear is that it is only by keeping existing members and attracting new ones that we can continue to offer a strong and united opinion to influence developments.

Membership Benefits

1. Provides access to UK Cardiac & Thoracic Surgical registers and National Adult Cardiac Surgical Database information enabling self regulation and monitoring of performance.
2. The SCTS organises an annual meeting with a full scientific and social program.
3. Access to the Society's website at www.scts.org offers a useful source of relevant information and enables access to CTSNet.
4. Provides a twice yearly newsletter.
5. Members are represented on the central Consultants and Specialities Committee.
6. Provides scholarships for members (both trainee and young consultants)
7. Offers career advice and pastoral support for trainees from the Cardiothoracic Dean
8. The trainees have an elected member who sits as their representative on the Executive committee and the SAC
9. The secretary of SCTS and Cardiothoracic Dean sit on the SAC and exam board to represent the interests of the SCTS.
10. There is an SCTS trainees' web page.
11. There are trainee meetings held at the SCTS annual meeting.
12. The SCTS approve various courses, which should aid the trainee in choosing where to spend education budgets.
13. Membership offers reduced subscription to the Journal for Thoracic and Cardiovascular Surgery
14. Provides opportunities to discuss clinical and other matters of common interest.
15. The SCTS offers pastoral and professional help in times of difficulty.
16. Maximum membership gives the Society more strength in representation and negotiations and therefore greater input into national matters of interest/importance.
17. Membership of the Society helps to further the improvement of standards in the care of Cardiothoracic patients in the UK

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Secretary's Report

James Roxburgh



The production of this bulletin requires an enormous amount of time and effort! What it does not need is a Secretary who always submits his article just as the presses begin to roll! However I hope Sunil will forgive me as I try and bring you all up to date with the inner workings of the Society. I know many of the members feel

that they are removed from the day to day work of the Society and that being on the Executive is simply an all-expenses paid jolly to London. The Executive members do work hard but we need to continue to reform the working of the Society and improve communication. I would ask that all of you take the time to read and comment of the Graham Cooper's report. I hope the items below will give an idea of what is going on at the moment.

We are all in this together

Ever since the prospect of the publication of surgeons specific data was first raised over five years ago there has been concern that this would lead to risk averse behaviour. Sam Nashef and his colleagues at Papworth have developed an extremely interesting mechanism to handle high risk cases that an individual surgeon might feel unable to tackle. The surgeons have agreed that any patient who has been turned down for surgery at another unit, has a logistic Euroscore of greater than 25, or is deemed an inordinately high risk case by an individual consultant is presented to a "Council" of surgeons. This group then decide if surgery is appropriate, and if it is, which surgeons at Papworth are best able to undertake the procedure. The operation is then undertaken by two consultant surgeons and the whole group and not just the two consultant surgeons who undertake the operation agree to take on the responsibility for the patients outcome. The concept is that these patients would be presented on the CCAD website and eventually the Public Portal as "Council" patients and would not be attributed to an individual. This should result in fewer patients being denied surgery because of concerns about risk averse behaviour and would have the added benefit of displaying to the politicians, the media and the patients that the team approach is the way forward. We are currently setting up a working group to look at this – volunteers please!

Who do you call?

All of us at some time or another will go through a bad patch at work, be it clinical results or relationships with colleagues. In many cases discussing the problem with a friend or

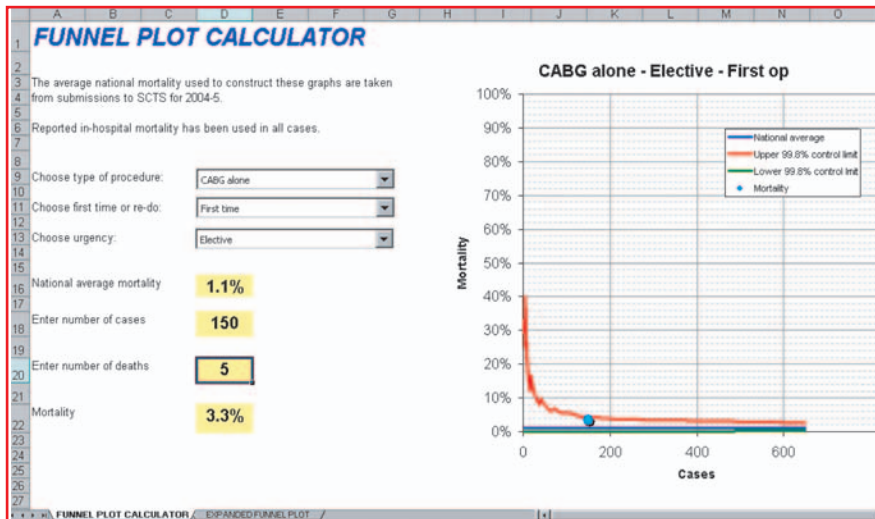
colleague will put the whole matter in perspective and it is back to work as usual. Indeed one of the many benefits of the Annual Meeting is the chance to swap stories and commiserate with friends and colleagues and realise that the grass is not greener on the other side. However occasionally problems at work escalate and may involve the BMA and the Defence Organisations, there is still though the need to discuss these problems with a neutral party. One of the important points made by the membership was the need for the Society to provide this support in a more formal setting. We have therefore gathered together a list of individuals who are prepared to provide the support. This is seen as a valuable service by the Defence Organisation I belong to but they stress

2004-05 % Below/Equal to National Median	Hospital	2005-06 % Below/Equal to National Median	Hospital
55.8%	Western Infirmary	56.5%	St Thomas Hospital
64.5%	Wythenshawe Hospital	55.5%	Wythenshawe Hospital
83.9%	St Thomas Hospital	51.8%	Freeman Hospital
60.4%	Freeman Hospital	43.8%	Western Infirmary
		33.5%	Papworth Hospital

that the Society must not get involved in clinical or legal matters. Please contact Isabelle Ferner or any member of the Executive for further details.

Time to go home

The CCAD database not only provides information about risk-adjusted mortality but also various markers of morbidity such as length of stay. Increasingly Trusts are looking to reduce the length of stay and are using HES data to assess their performance compared to a national average. At the recent audit leads meeting the new length of stay data was demonstrated. This uses median length of stay (post-operative) and shows the proportion of patients in a unit that state less than the national median. The demonstration (see attached screenshot) shows only four units but when rolled out it will be possible to see the data for all units in the UK and it will be subdivided by the common operation groups. Surgeons will be able to see this data via the CCAD link for their unit and I hope it will be available resource.



come easily! However it is important that the membership are able to learn more about the Executive process and it is therefore been agreed that a summary of the minutes will be sent out after each Executive meeting. This summary will be based on the nine points identified in Graham Cooper's document. Any member who wishes to see the full minutes can do so by requesting these from Isabelle Ferner, however I would hope that the summary will be easier to read and provide all the information you require.

All work and no play

The recent job survey undertaken by SCTS (GB&I) Ltd has been circulated to all

Consultant members and can of course be downloaded from the members section of the website. We will continue to analyse responses for the next month or so and I would therefore urge those of you who have not returned the questionnaire to do so as soon as possible.

What is SCTS (GB&I) Ltd?

This is the commercial arm of the Society. The Society is the sole shareholder and can direct this company to undertake tasks that fall outside of our charitable remit. There are three directors; Patrick Magee, Peter Goldstraw and B Sethia, the rules state that the majority of the directors cannot be members of the Executive. It has been agreed that the immediate past-President will always be a director and that thoracic surgery should always be represented. It is quite a complicated process setting up the financial structure of such company and we are still defining the exact role it will play. However it has already allowed us to undertake the job survey and I hope it will allow us to expand the services we provide to the membership.

How am I doing?

A few years ago Dendrite produced a funnel plot calculator for first-time coronary artery surgery based on SCTS data, which they very kindly made available to all Society members free of charge. However it was felt by many that they would like this facility extended to other operations. I am pleased to say that David Cunningham, who works tirelessly to improve the quality of our data, has produced an Excel based funnel plot calculator for a wide variety operative conditions (see screenshot). Currently this is based on raw mortality data and although this has taken a huge amount of work to produce it may be possible to expand this to include risk profiled data. This can be downloaded from the members section of the website.

The defence rests

As Secretary I often get approached to suggest surgeons to provide a medico legal opinion. The current lack of any formal structure makes it difficult to provide the lawyers and ultimately the patients with appropriate guidance. It is therefore been decided that we should set up a list of Society members who wish to be approached to provide a medico legal opinion. Leslie Hamilton has drawn up a pro forma to enable members to register their interests and this will be shortly available for download from the website and more detail is available in his article later in this Bulletin issue. A detailed letter will be going out to all the consultant members in the near future. It is important to note that the Society cannot take any role in deciding whether or not an individual member is able to provide medico legal advice in the areas that they have indicated, the Society is purely acting as an honest broker in the interests of both the members and the patients.

Who is the best

A not infrequent call to the Society office will be from a patient or a GP asking who they should refer a particular patient to. Whilst the Society cannot in any shape or form recommend an individual member it would seem appropriate that we should at least be able to guide these callers to members who have a professed interest in a particular clinical area. We thus plan to use the information provided on CTSNet when members register their surgical areas of interest. Once again the Society is acting as an honest broker and cannot be held legally responsible for any claims made by a member.

Insomnia?

The minutes of the Executive are pretty dry and turgid documents and after reading 16 close typed pages sleep will



Report from the Chairman of the SAC in Cardiothoracic

Chris Munsch

Workforce

Unfortunately the situation does not appear to be improving, and the number of CCT holders without consultant posts continues to increase. The SAC continues to explore all potential avenues but to be fair I can't say we are making much progress. There do appear to have been a trickle of jobs coming through in 2006, but clearly not enough of them. Some units have been able to debase deanery funding into service posts with a view to providing short-term employment for CCT holders. We have also asked for a review of the situation in thoracic surgery, in the hope that new jobs may become available, and we will keep everyone informed. The unavoidable fact is that the future will lie with a reconfigured workforce, and the SAC and the SCTS executive are currently updating Peter Goldstraws earlier report on new ways of working in cardiothoracic surgery, as we believe the 'times have already changed'.

Selection into Cardiothoracic Surgery

Following a two year moratorium, there will be one 1 NTN per programme this year although we are concerned that this may be too many. For the next 2 years we would anticipate selection into ST3 from the large pool of LATs and other doctors already in the speciality. For each of the next two years we would expect to see approximately 5 new NTN's appointed nationally, with a central selection process and matching of successful candidates with appropriate programmes. We are currently developing our selection methodology to support this process. By 2009 we would envisage joining in with MMC and run through training. We will no longer appoint new NTN's specifically to thoracic surgery. The concept of a totally separate training pathway within an established training programme is not acceptable to

PMETB. It is clear that a separate training pathway is a major step on the road to a separate speciality. I am not sure that is what anyone wants. Much more preferable is the concept of core cardiothoracic training taking around 4 years (ST3 – ST6), followed by 2 years (or more) of subspecialty training. Incidentally, the thoracic NTN's were introduced primarily to attract trainees away from lucrative cardiac surgery into unpopular thoracic surgery – a set of circumstances that no longer exist.



Quality assurance of training programmes

In the PMETB era the 'old fashioned' SAC visits have been replaced by a combination of regular local QA with SAC input, and occasional 'jumbo' PMETB visits. We have suggested that all training programmes should now get together with their Deans and undertake a review of training and consider plans to redistribute and reduce trainee numbers. The SAC can provide support and advice for this process.

Curriculum

The new curriculum comes into force in August 2007, and by now everyone should be able to access and use the fixed parts of the web site, www.iscp.ac. The interactive sections continue 'under development'. The Electronic Logbook continues to try our patience and despite assurances from logbook designers, we do not yet have a logbook that does what we have asked. Our logbook Tsar is discussing other options.

Society Scholarships

The Marian & Christina Ionescu Travelling Scholarship

Through the generous endowment of Marian & Christina Ionescu, the Society will be awarding for the third year this Scholarship for the sum of £10,000. This award is earmarked for newly appointed consultants who are in the developmental stages of their career. The stipend is a contribution towards travelling expenses.

Society Thoracic Fellowship

The thoracic fellowship is available for trainees who have been Society members for at least 2 years and require financial support to undertake a thoracic fellowship.

Deadline for all Scholarships is strictly 14th February 2007. Application forms and further details may be obtained by contacting Isabelle Ferner at sctsadmin@scts.org.



Collaboration needed for workforce changes

Tara Bartley, Nursing Representative



Since my appointment in May I have concentrated upon improving communication. We are all aware that the current changes in the NHS are having a profound effect upon nursing and associated professions. The challenge set by national changes in cardiac practice, medical training and broader issues faced by the NHS has created an unsettled period that calls for a proactive approach amongst health professionals.

I am pleased to say that the national network of contacts in all cardiothoracic centres is almost complete. This has enabled the database to expand, opening channels of communication. The following regional representatives have been established:

Scotland & Ireland - Linda Mckee Cardiothoracic Specialist Practitioner, Glasgow Western Infirmary

North East England - Davis Purdue, Clinical Nurse Manager, Nottingham City Hospital

North West England - Georgina Aldous Cardiothoracic ITU, Cardiothoracic Centre, Liverpool

East Anglia - Helen Munday, Clinical Research Nurse, Papworth Hospital

I am covering the **Midlands, London & the South, South West and Wales**. Tony Jessop, chairman of the society for Surgeons' Assistants, is liaising with the Surgeons' Assistants. A circular has gone to all on the database requesting the dissemination of current information and this highlights the need to liaise about existing and new initiatives, protocols, ways of working etc. It is important that we take an active role and help steer the workforce changes that will need to take place in light of the impact of MMC. Nursing and associated professions need to create opportunities and work

collaboratively with our colleagues to underpin the speciality of cardiothoracic surgery. With this in mind, the theme at this year's Annual Meeting Forum is the patient pathway and collaborative working.

I am delighted to inform you that Maura Buchanan, the incoming president of the RCN, will give the open remarks. There will be an opportunity to contrast a surgeons' and nurses' perspective with that of a patient from both cardiac and thoracic surgery. For those of you who wish to brush up on your cardiothoracic assessment skills there will be an interactive session with an emphasis on how developing such skills can enhance care as traditional roles expand.

We will also be looking for suggestions from delegates as to how we as a group can further amalgamate with the surgeons. There will be an opportunity to review options for membership of the SCTS among nurses. This important issue may result in the expansion of the SCTS and increase our input into the Society.

To promote this concept I am pleased to report that the nurses' page on the SCTS web site is open and accessible to all. We have removed the login process pending discussion at the Forum and expanded the information. We welcome your comments and ideas. If you have any burning issues or key developments you would like to air please contact me with a view to placing them on the page.

We look forward to seeing you in Manchester and may I remind you the early bird registration for the forum is £75 per day until January. Not only will the conference be good value but it compares favourably with other conferences of the same calibre.

If you have any comments, ideas or matters that you would like to raise I welcome your emails - contact me at tara.bartley@ntlworld.com.

How will your unit be staffed in five years time?

Steve Livesey, Executive Member

Well almost certainly not in the same way it is now. With the advent of Modernising Medical Careers next year and the reduced need for cardiothoracic trainees, the "Surgical Registrar" will no longer have the pivotal role in the day to day running of Cardiothoracic Units. Even if the status quo was desirable the reduction of permissible working hours under the European Working Time Directive - from August 2009 the maximum working week will be 48 hours - will make this impractical.

There is a vision of the future. Surgical trainees will be almost entirely supernumerary and will spend their time at work being trained. The daily tasks required in order to run the unit will be undertaken by permanent members of staff who are appropriately trained. For example, surgical care practitioners will clerk the patients, assist in the operating theatre, look after them on the wards and see them for follow-up; nurse specialists will run high dependency units making most of the hour-to-hour management decisions and anaesthetic and

Trainees Update

Farah Bhatti, SCTS Trainee Representative

The jobs crisis facing CCT holders remains high on the agenda at both the SAC and SCTS Executive meetings. As you are aware from previous email updates, COPMeD met in April this year and decided that grace periods would not be extended beyond the standard six months plus a discretionary six months (i.e. one year from CCT date). A few consultant posts have been advertised in the last few months, but so have a number of clinical fellow posts aimed at CCT holders; whilst these are a means of staying in employment, the clinical fellow posts do not have the same responsibilities, or salary, as SpR posts. I brought this up at the last Society Executive meeting in September, and asked for both support and for a formal statement from the SCTS to be put out to all trainees about the current situation. In the meantime, for those who have not approached CCT, it seems that delaying your date can be achieved only by means of a RIT E.

The new style FRCS (CTh) examination starts in 2007. This will consist of Section 1 with 2 MCQ papers of 2 hours each (Paper 1: Single Best Answers (SBAs) and Paper 2: Extended Matching Items (EMIs), followed by Section 2 consisting of Cardiac and Thoracic Long Cases, Short Cases and Orals (i.e. no Basic Science Oral). The written papers have to be completed successfully before proceeding to Section 2; after this, they have no bearing on the final outcome of the exam. Section 2 has to be done within 3 years of completing Section 1. All six sections in Section 2 have equal weighting and the scores will be added to give a cumulative final score. The results will be sent out within 4 weeks. A pilot for the written exam, open to all trainees, was carried out prior to the Birmingham Review Course in September. One piece of feedback I received was that many people did not complete the SBA paper – so time management is something to bear in mind if you are sitting the paper in January.



I'd like to remind everyone to take a look at Intercollegiate Surgical Curriculum Project website (<http://www.iscp.ac.uk>) and feedback any comments to me. I would also encourage you to 'road test' the pilot Procedure Based Assessments that I have circulated, so that any fine-tuning that may be necessary is done before the final versions.

Lastly, plans for the Trainees Day at next year's Annual Meeting in Manchester are being finalized. The programmed includes Leslie Hamilton speaking about the new intercollegiate exam, Doug West on the European Working Time Directive and training, and Terry Hubble, a Mountain Climbing Instructor, speaking on Teaching Complex Skills in a High Risk Environment. David Sodden has also been invited to attend. The hour-long trainees' meeting has been left entirely free so that any trainee who wishes to raise any topic will be free to do so (farahs_email@yahoo.co.uk).

critical care practitioners will manage patients peri-operatively and in the Intensive Care Unit. "Trust doctors" will also have important roles throughout the pathway of care.

Clearly this vision is by no means universally embraced. Few units look anything like this at the moment – but even if this vision is not the "end of the journey" it is certainly the direction of travel. So how do we get there – or at least move in that direction.

A joint Cardiothoracic SAC / SCTS working group has been established to develop on some of the messages in the 2005 document "Exploring New Ways of Working in Cardiothoracic Surgery". This document is available for download on the members page of the SCTS website. The members of the working group are: Steve Livesey, Tim Graham, Tara Bartley & Graham Cooper. We would be pleased to hear from anyone who has a particular interest in this area and will report on progress at the Annual meeting in March.

Homograft Valves and the Human Tissue Authority

Mr Stephen Langley, Consultant Cardiac Surgeon

Dr Sandy Mather, Director of Regulation at the HTA (Key responsibilities: licensing and inspections)

Introduction

The Human Tissue Authority (HTA) is the independent statutory regulator established by the Human Tissue Act 2004, and was set up on 1 April 2005. The Human Tissue Act applies to England, Wales and Northern Ireland. There is separate legislation in Scotland, the Human Tissue (Scotland) Act 2006, and the HTA performs certain tasks, including licensing establishments storing tissue for transplantation, on behalf of the Scottish Executive.

What's new?

The Human Tissue Act 2004 repeals and replaces the Human Tissue Act 1961, the Anatomy Act 1984 and the Human Organ Transplants Act 1989. The Human Tissue Act makes consent (called authorisation in Scotland) the fundamental principle underpinning the lawful storage and use of body parts, organs and tissue.

Who are the HTA?

The HTA is an Executive Non-Departmental Public Body. This means they are an "arms length" organisation to the Department of Health (DoH). They are sponsored and part funded by the DoH. The HTA consists of 17 members appointed by the Secretary of State for Health. The Chair and eight of the members are lay and have no professional interest in the area of human tissue. The remaining eight members are professionals drawn from some of the groups directly affected by the new legislation. A core team of twenty staff led by a Chief Executive manage the day-to-day running of the organisation.

What does the HTA do?

The role of the HTA is to regulate the removal, storage and use of human bodies, organs and tissue for a number of 'Scheduled Purposes' set out in the Human Tissue Act 2004. These Scheduled Purposes include transplantation, research, education and training.

What's it got to do with us?

From 7 April 2006 any establishment in the UK storing human tissue or cells for transplantation must be licensed. Licensing is undertaken to meet the requirements of the European Union Tissue and Cells Directive 2004. This is done via the Human Tissue Act and the associated Department of Health

Quality and Safety Regulations. It is now unlawful to carry out licensable activities without a licence and the ultimate penalty is up to three years imprisonment. Tissue banks were previously accredited by the Medicines and Healthcare products Regulatory Agency (MHRA) under a voluntary Code of Practice. These establishments are now licensed on a statutory basis by the HTA.

But we don't have a tissue bank.



The majority of cardiothoracic units in the UK do not have their own heart valve bank and therefore need to procure homografts from one of the seven licensed banks in the country. If a homograft or any other tissue is used within 48 hours then a licence is not required by the implanting hospital. However a problem arises when, for whatever reason, the homograft is not used within 48 hours. This happens if a case is cancelled or postponed or if at the time of surgery the homograft is not needed. It is no longer acceptable to store the valve locally, in a theatre freezer for example, without a licence. The licensing standards are intended to ensure that material for transplantation is kept in an appropriate environment with clear monitoring and temperature and storage conditions. This preserves the quality of the material for transplantation.

Do we need to do anything?

Your trust should have identified a Designated Individual (DI) and Licence Holder who are responsible for obtaining a licence from the HTA for all human tissue procured, processed and stored within the hospital. Larger trusts may have a number of different DIs covering different specific areas. If your hospital has a heart valve bank this should now be licensed. If your department stores homograft valves, even occasionally, for over 48 hours this must now also be licensed. The DI for your hospital should be made aware of this. By definition though, if you store human heart valves for over 48 hours you should have a tissue bank. As such the HTA Codes of Practice and Directions must be followed. These supersede the voluntary Code of Practice for Tissue Banks published by the DoH and the European Union Tissue and Cells Directive.

If you are not sure what to do contact the HTA on www.hta.gov.uk where you will find several useful guidance documents, or email enquiries@hta.gov.uk or call 020 7211 3400.

P.S. from Steve: With the current shortage of consultant jobs I have no doubt some of the trainees would be happy to see a

number of us doing some time inside! For most of us I suspect this can be avoided. Perhaps one surgeon in each unit should take overall departmental responsibility for homograft usage and storage. From my own dealings with the HTA I have found them extremely approachable. They are very much there to help us get licensed appropriately and responsibly.

New Library at the Royal College of Surgeons, England

*Kate Homer, Information Specialist Library & Information Services,
The Royal College of Surgeons of England*

'Specialist Libraries' are an integral part of the National Library for Health, a library and information service for the NHS that aims to deliver a range of services to support patient care, staff development and research. On 30th June 2006 the Specialist Library for Surgery, Theatres and Anaesthesia (www.library.nhs.uk/theatres), an easily accessible and up-to-date collection of evidence-based guidance, practical websites and patient information, was made available from the NLH site.

The Surgery, Theatres and Anaesthesia Library supports the information needs of everyone in the theatre team. Its scope includes all resources relating to perioperative management, cutting across the medical specialties and emphasising important topics such as infection control and patient safety. It is managed by a project team based at The Royal College of Surgeons of England, along with clinical partners from the Royal College of Anaesthetists and Morecambe Bay NHS Trust; the latter had involvement in earlier work investigating information needs within the theatre team which has fed into the project.

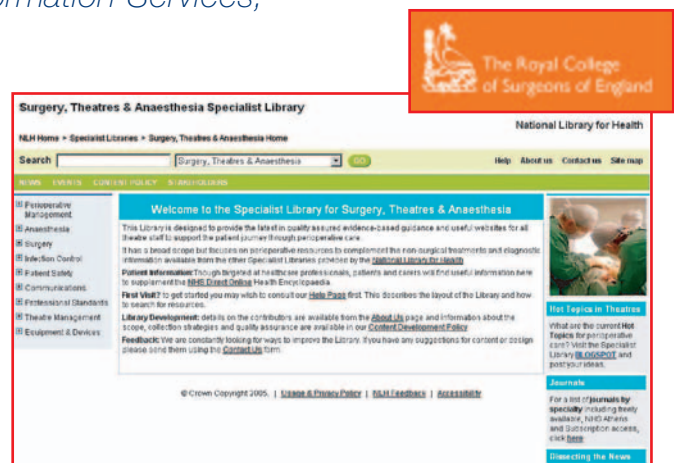
Community of practice is central to the Library, and to foster this sense of collaboration and ensure practitioner input, the Library has engaged support at different levels. At a very practical level, the Library has sought 'Topic Advisors', individuals who can be called on to offer advice on the quality, relevance and currency of resources within their particular field of practice. They also have a role in alerting the Library to important topics in their specialist area and helping to develop editorial processes. If you would like to get involved with the Library at this level, please get in touch.

Partner organisations, including AfPP, also have a role in the governance of the Library. Representatives attend an annual

meeting to discuss development and feed back on the resources reflecting their professional area, and ensure that the Project Team meet their milestones.

At the time of writing the Library has collected NHS funded evidence-based resources as its core content, including guidelines, Cochrane Systematic Reviews and Clinical Evidence topics. Patient information from partner organisations and some reference material has also been added. All resources outside the core content are subject to strict quality criteria and assessment by Topic Advisors. The process of collecting content has begun to reveal gaps in the evidence which may serve to inform the next stage of content collection, along with user-led ideas for topic searches and suggestions for key resources.

The Library is a work in progress, and its future development and value depend on feedback from its users. The testing phase starts now - if you have any comments about the site or suggestions for resources please email us at speclib@rcseng.ac.uk or visit the blog at <http://theatreslibrary.blogspot.com/> to post your ideas or contact me (khomer@rcseng.ac.uk).



Thoracic Surgical Audit Project

Richard Page

The SCTS thoracic surgical register for the years 2002 to 2005 is now available on the Society website. It provides a summary of returns from 36 out of the UK and Irelands 39 hospitals currently providing thoracic surgical services. The exceptions have been returns from Plymouth, Glasgow Royal and Glasgow Hairmyers which unfortunately have not been available. Nevertheless I estimate the returns comprise over 95% of thoracic surgical activity carried out throughout this period.

At the 2006 annual meeting in Dublin I presented a summary of variations in activity between hospitals, which led to some interesting comparisons. This work will be presented in greater detail in the forthcoming Blue Book, along with cumulative activity from the register since it's founding in 1980.

My current task is to collect returns from colleagues throughout the country for the year just completed, 2005-2006. So far eighteen out of the forty-one active Units have

sent in their activity, including five thoracic surgical dataset returns (as developed by Tom Treasure for the SCTS). The latter will provide much more detailed activity with respect to resections of primary lung cancer, such as information on pre-operative status, complications and length of stay, as well as mortality. As I have emphasised on previous occasions all outcomes will be Unit based; no surgeon-specific data will be collected for thoracic surgery.

In the near future I will be writing once again to audit leads from around the country, gently reminding them of their responsibilities! As always I am grateful to all surgeons and audit managers who have helped with what I know is a worthwhile project.

If anyone has any questions then please do not hesitate to contact me personally in Liverpool at richard.page@ctc.nhs.uk or on 0151-2932456.

SCTS Clinical Leadership Workshop

Ben Bridgewater, Executive Member

It has become clear over recent years that good quality healthcare comes from services which are both well organised and led. The importance of high quality clinical leadership was recognised by the Bristol Public Inquiry and more recently has been acknowledged in the Chief Medical Officer's report on medical revalidation 'Good Doctors, Safer Patients'. Most successful organisations outside healthcare invest significantly to improve the quality of their leadership.

The close scrutiny on outcomes in cardiac surgery in the UK has resulted in the development of clinical leadership expertise in CT surgery which is advance compared to other areas in medicine. This has been driven by the need to deliver low mortality in a heavily monitored environment, managing outlying performance and delivering demanding targets for both cardiac and thoracic patients. However, to date, this process has not been coordinated. It would seem appropriate for a professional society such as the SCTS, whose role is to improve the quality of care for patients receiving cardiothoracic surgery, to facilitate the development of high quality managerial and leadership expertise within its membership.

The executive has agreed to support a clinical leadership workshop, which will be a 2 day course designed for current or aspiring clinical directors within the SCTS. The workshop will have 2 functions; to enable sharing of experience and best

practice between those managing directorates. It will also provide an opportunity to learn and develop further theoretical and practical management and leadership skills using small group working. The exact structure of the course will be tailored to the needs of the participants but is likely to include sessions on personal attributes for successful leadership, effective change management, managing poor performance, appraisal, using incentives to improve services, celebrating success and using information to drive quality. The workshop will be led by a commercial firm with significant expertise and experience of working in healthcare, supported by a small faculty of cardiothoracic surgeons. The course will be held in the St Jude educational facility in Stratford upon Avon, and will be jointly subsidised by the SCTS and St Jude. Provisional dates have been booked for 11th and 12th April 2007. Participants who are members of the SCTS will be charged a nominal fee only.



For further information or to reserve a place on the course please contact Ben Bridgewater at ben.bridgewater@smuht.nwest.nhs.uk.

The FRCS Cardiothoracic Examination – changes are constant

Leslie Hamilton, Chairman of the Intercollegiate Board

In the mid 1980s, the Royal College of Surgeons in Edinburgh saw the need for an “exit” exam in the surgical specialties. In 1991 this became Intercollegiate and in 1996 became compulsory for the award of CCT. The Exam has evolved over the years and more recently, with the inception of the Postgraduate Medical Education and Training Board, developments have accelerated under the guidance of medical educationalists.



From 2007 the Exam will be in a new format – a written paper will act as a screening test and achieving a standard in this will be a requirement to proceed to the clinical section. The most significant change is that the Basic Science Oral will be incorporated into the written paper. The new clinical part of the Exam will be essentially the same as at present – in both cardiac and thoracic a candidate will review a “long” case (30 minutes), have 30 minutes to review 4 “short” case stations – 2 with patients to review clinical skills and to test interpretation of investigations. There will then be a 30 minute oral examination with a discussion on structured clinical scenarios.

The marking scheme will also change - the Educationalists feel the reliability of the Exam will be improved by having an increased number of marks. At present the Examiners agree an overall mark for each section. Under the new system each Examiner will give an individual mark for each component of each section of the Exam. One drawback is that it will not be possible to give out the results on the day.

The entry regulations have changed to allow Surgeons who are not in training posts to take the exam (PMETB directive) – no longer linked to completion of Year 4 of training. However the standard for entry remains the same – as the Exam does not test technical skills, the candidate will be expected to be a technically competent Surgeon in the generality of the

specialty. Entry will be on the basis of 3 detailed structured references which will state that the trainee/candidate is at the end of their training i.e. has achieved all the competencies defined in the surgical curriculum (www.iscp.ac.uk). The expectation is that trainees taking the exam will be in their final year of training within a year (although under the new Curriculum training will not be based on years but rather achieving competencies). Thus any trainee who is successful in the Exam should be awarded their CCT within one year.

Unlimited attempts will be allowed at the written paper but success in the clinical section must be achieved within 3 years of passing the written paper. Three attempts will be allowed in the clinical section. Some trainees have raised the question of the fee for the examination – £425 for Section 1 (written paper) and £1275 for Section 2 (Clinicals). The Exam Boards are self financing and the fees have to cover all the administration (both the Exam Board Office and the local costs for the Exam). In addition, development of the written paper has been costly – Examiners are not paid but travelling expenses are covered. The Educationalists asked for 800 questions in the question bank and on average 40 questions per day were produced by the editorial teams. It is worth remembering that the fees for trainees in other professions are significantly more.



The most recent diet of the exam was held at Southampton in October 2006. Of the 32 candidates who entered the exam 53% passed. The pass rate amongst NTN undertaking the exam for the first time was 85% (11 passes from 13 candidates). It was noted that although some candidates had a good knowledge base, their clinical skills were lack lustre and future candidates should ensure that they are proficient in history-taking, consent and examination of patients.

Expert Witnesses - are you one?

Leslie Hamilton, President-Elect

Our legal system is an adversarial one in which a patient has to prove blame in order to receive compensation for injury sustained during medical treatment – the issue of “no fault compensation” (as in New Zealand) has been discussed on many occasions but so far has been rejected in the United Kingdom.

Our system relies on the Courts receiving evidence from “medical experts” as to the standard of care which should have been provided. Both the Claimant and Defendant will seek reports and then it is up to the Court to weigh the evidence and decide on the standard of care. A review of the process by Lord Justice Woolf produced the “Civil Procedure Rules” – the most important change was that reports by Experts were prepared for the Court rather than for each individual “side”.

Solicitors often struggle to obtain reports in the smaller specialties as many Consultants are unwilling to undertake this work – this is understandable as on occasions it requires being critical of care provided by a colleague. However the system can only work if these reports are provided. We are only human and therefore there will almost certainly be occasions when the standard of care, for whatever reason, falls below which we would like to have provided – we should therefore not take it personally if a medical report is critical. If a patient deserves compensation they do have to attribute blame.

The Society is often approached by solicitors asking for suitable experts. The Executive did consider providing such a list but the Academy of Medical Royal Colleges has advised against this – it would imply endorsement of particular experts. The Executive therefore proposes to maintain a list, which would be made available to enquirers and it would then be up to the solicitor to establish contact and decide on the suitability of an expert – there is no fixed

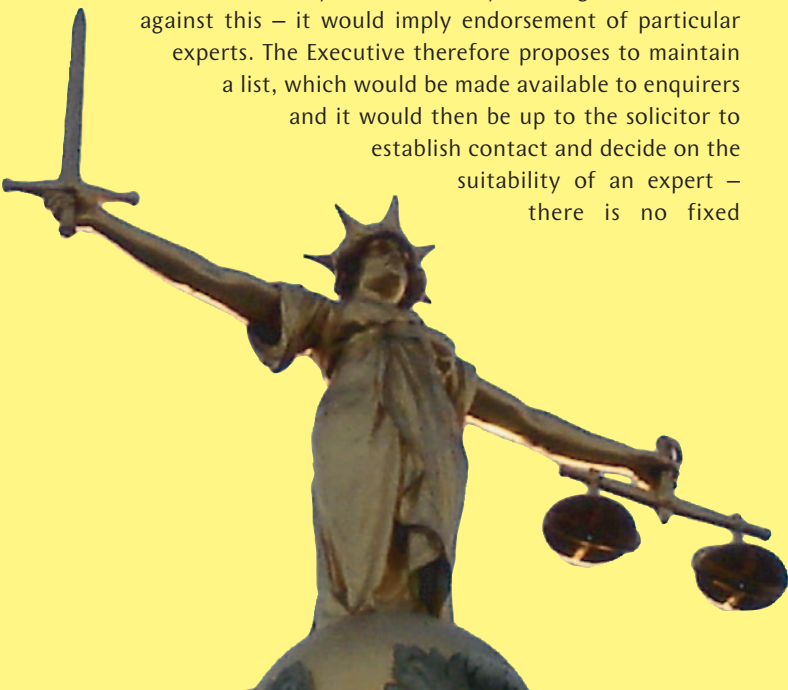
definition but essentially the Courts are looking for information on the standard of care at the time of the incident. In the past, experts were often those who had retired and therefore had the time available. The Courts are likely to discount evidence from someone who has been out of practice for some time. However, a patient can bring a claim up to 3 years after becoming aware that there may have been a problem – by definition a child does not become aware until they are 18.



Thus paediatric cases can go back 21 years – someone able to give evidence on the standard of care applicable 21 years ago will almost certainly be retired!

You will be receiving a letter from the Society asking if you wish to be included on such a list. It is important in the current era that anyone undertaking medical expert work has undergone training in preparation of reports and presentation of evidence.

The Courts are likely to discount evidence from someone who has been out of practice for some time



Surgical care practitioners: where are we now?

Samer A M Nashef

Brief history

Most of you will be familiar with the development of the role of surgical assistant or surgical care practitioner (SCP) in our specialty. After the first experiment with a surgical assistant in Oxford, the Papworth programme was set up at the beginning was by using funds that were available for reducing junior doctors hours. This gave us two surgical assistants and allowed us to train them. At the end of their training, they immediately resigned and went off to establish programmes elsewhere, but not before truly proving their worth and allowing us to expand the programme. We made a case for four SCPs to continue the reduction in junior doctors hours and to ensure that the service in theatre could go on without disruption.

At the same time, other programmes were beginning at various parts of the country. At first, many of the trainees came to Papworth for a period of around six months on average, but most cardiothoracic centres with SCPs currently train their own, often in collaboration with local higher education establishments. Cardiothoracic SCPs established ACSA, a specialty association which has an annual general meeting with scientific papers and topics and provides an excellent forum for our SCPs. The SCTS has temporarily granted ACSA members free associate membership and provided encouragement to them to attend our annual meeting and forum. At the same time, there was a keen national interest in the development of such roles in all surgical specialties by both the Royal College of Surgeons (RCS) of England and the Department of Health. Several collaborations began, faltered and restarted. A new organisation, the National Association for Assistants in Surgical Practice (NAASP) was set up and took over much of the development and documentation of the roles and the curriculum.

Current status of training and certification

Nationally, there is now a core curriculum (what every SCP should know) and a specialty curriculum (dealing with cardiothoracics, orthopaedics etc...). Training is said to take two years (one in each) but the core curriculum should be transferable for SCPs who change specialties. There are plans for the introduction of national core and specialty examinations and a plan for a register of trained SCPs to be held, perhaps at the RCS.

Cardiothoracic SCPs have had an annual examination for several years. This is currently held at Papworth in November and consists of a written exam (modified essay questions) and a viva by two consultant surgeons. Satisfactory performance

in the exam together with a certificate of completion of two years' training are rewarded by the issuing of a Cardiac Surgeon's Assistant Diploma, as agreed between the RCS and the SCTS more than a decade ago. This exam will continue to be held until the national initiative is robust and functioning well, when I shall be



pleased to hand over this particular task to the national bodies that will oversee it in future. In the meantime, however, we do need a method of certification and the exam continues to attract candidates and is generally well regarded. Agreement has been reached with the RCS that cardiothoracic SCPs with the Diploma will be recognised under a "grandfather clause" in the new certification structure.

Areas of controversy

Many of you will have recently seen some fairly vociferous objections to the development of such roles in the medical and lay press. Most of these are, in my opinion, totally without foundation, but they often follow four distinct lines, which I shall deal with below.

1. The clinical quality argument

This usually goes: "patients should be operated by doctors, not by technicians and nurses trained on the cheap" or something to that effect. In practice, the argument does not hold water. The task of assisting and of harvesting vein and radial arteries is often left to relatively junior members of the surgical team who may not have received any formal training in these techniques. This leads to substantial conduit and harvest site problems. It can be argued quite strongly that the interests of clinical quality are better served by having these tasks performed by properly trained staff. As most doctors do not want to spend their lives harvesting conduits, this job is better delegated to those with an interest in performing it as part of their career and performing it well. Studies of complication rates comparing the results of conduit harvest by SCPs and SHOs reinforce this view.

2. The training argument

This usually states that SCPs "rob junior doctors of valuable training opportunities". I cannot comment on other specialties, but in cardiothoracic surgery this argument is, in reality, nonsense. There have been precious few studies on the

Continued on page 16

impact of SCPs on training of junior doctors but, invariably, every single study that has looked at the subject has found that training of junior surgeons actually improved rather than suffered as a result of the presence of SCPs. In cardiac surgery, junior doctors can be trained by a patient, experienced and competent SCPs in the conduit harvest. Once they reach a certain level of proficiency in this, they are free to undergo further training at the chest end. One survey that we carried out showed that SHOs invariably did more sternotomy, cannulation, mammary harvest, anastomoses and whole cardiac cases in units with SCPs than in units without. There is, therefore, absolutely no supporting evidence for the argument that SCPs devalue the training experience for junior doctors.

3. *The professional boundary argument*

This usually goes: "Nurses are performing surgery on patients! Shock! Horror!" This can be countered by re-stating what makes a surgeon. An SCP who assists in an operation or who performs certain parts of it after due training, under supervision and within agreed protocols is most certainly NOT a surgeon. Surgeons are no more defined by the wielding of a sharp instrument than physicians defined by the wielding of a pen on a prescription pad! What makes a surgeon is the following:

- knowledge (necessary to decide when to operate, on whom to operate and when not to operate)
- judgment (necessary to decide how to operate, provide care before and after operation, and what to do when things do no go according to plan)
- accountability (necessary to take responsibility for outcomes)

SCPs do not have these abilities and in most cases they do not wish to acquire them. If they did, they will need to go through medical school and surgical training. Only then would they become surgeons.

4. *The liability argument*

This is the concern about what would happen if there are complications related to action performed by SCPs. These

concerns are bogus. Provided the hospital establishes that no individual in the hospital performs tasks for which he or she has not been trained and provided it is accepted that SCPs work as an integral part of a team of surgeons and always under the direct or indirect supervision of the consultant in charge, there really should be no cause for concern. After all, a complication that arises from an SCP harvesting a segment of vein is no different to a complication that arises from a SHO or Registrar harvesting a piece of vein. On the contrary, it can be proven relatively easily that the rate of complications with experienced SCPs tends to be lower than that with inexperienced junior doctors.

The future

SCPs are quite likely to be here to stay. Provided our voice is heard in the national debate, their role across specialties has a chance of developing along sensible lines, but there is much that we can ourselves do to ensure a happy future for the role in our own specialty. I firmly believe that the success of an SCP programme depends on the breadth of the SCP remit. For their job to be rewarding, SCPs must feel they are part of the surgical team: they should see patients before and after operation as well as participate in the operation itself. They should be involved in research and audit, particularly when related to their field. There is also room for employing them in out-patient clinics, ward care and, to some extent, in the intensive care unit. Of course, the requirements for their deployment will be determined by local need but, wherever possible, we should try to ensure that they enjoy the job satisfaction that can only be obtained from a broad remit and a feeling of true belonging to the surgical team of which they are part. In brief, they should be true assistants in surgical practice, not "vein stripping merchants".

Our specialty has "blazed a trail" in this field as it has in so many others. We must, however, continue to be vigilant if the role is to develop along lines compatible with our aims in clinical care, training and providing a quality service. If you have SCPs, please look after them. If you don't, you and your patients are missing out!

Marian & Christina Ionescu Fellowship for Cardiac Surgery

Following a generous donation, the British Heart Foundation invites applications from Cardiovascular Surgeons in training to compete for a small number of Fellowships commencing Autumn 2007. The purpose of the Fellowship is to enhance training skills and career development relating to the perfection of cardiovascular surgery or research. Candidates should be EU citizens in permanent residence and training in the UK. Awards will be up to 2 years for further training (excluding routine surgical training), study or research in the UK, or abroad with the expectation of returning to the UK.

An application form and further information is available from our website: www.bhf.org.uk or telephone: 020 7487 9408 or email: research@bhf.org.uk. Closing date for applications: 30 March 2007 (decisions end of July 2007 – applications for retrospective funding will not be considered).



The Journey from Scrub Nurse to Surgical Care Practitioner: A Personal Account

Dawn Franklin, Surgical Care Practitioner, Southampton

Prior to undertaking this Surgical Care Practitioner (SCP) role I was a cardiac scrub nurse for 13 years, working at Southampton General Hospital (SGH) and in the USA in adult and paediatric cardiac surgery, including transplantation. Whilst in America, I was also trained in suturing techniques and first assisting. When the SCP role was introduced at SGH I perceived this as an ideal opportunity to utilise the skills assimilated in America. I was also looking forward to having daily contact with the patients and affecting a continuity of care.

The SCP Course (Degree level 3) that I undertook was held at Greenwich University London over two terms. The course was generic, covering all areas of surgery including surgical skills i.e. suturing, knot tying, urinary catheterisation, surgical incisions and tissue dissection. The SCP then related the course contents to their specialist areas where they worked supported by a Consultant surgeon. The knowledge and clinical experience gained was then evaluated in the following ways:

- Term 1** Skills and knowledge competencies
4000 word reflective essay
- Term 2** Skills and knowledge competencies
Written examination

The course required that a Consultant cardiac surgeon mentored me throughout my training and personally supervised my surgical skills training. The consultant signed all clinical competencies and regular meetings were held to evaluate my progress and review my training. I was seconded to other areas away from cardiac to fulfil the generic competencies required i.e. anaesthetics, general surgery, which were again supported by a Consultant. In addition to the SCP course I also attended the Bristol Surgical Assistant Anatomy Course and sat the Royal College of Surgeons Cardiothoracic Surgical Assistant Diploma examination.

Whilst the training at SGH was to a very high standard, the introduction of the SCP role was quite difficult. I was placed with one surgeon and worked alongside his Registrar and Senior House Officer (SHO) on the wards and in theatre. I found this very rewarding because I saw the patient throughout their hospitalisation and assisted in the management of their care.

However, there were times when the SHO was unavailable due to nightshift and on call commitments when I was required to take over their more extended role on the ward. At the same time other surgeons were requesting my assistance in theatre either to act as the SHO with vein harvesting, supporting a

junior SHO or simply to close the leg wound and assist with the chest closure. I soon found my role was ever expanding. Although I gained great fulfilment from this extensive role I found that my hours were extending far beyond my legally allocated hours, which was becoming a concern for the cardiac managers. Fortunately at this time another opportunity arose at the local private hospital, where I was subsequently appointed.

I now work at BUPA Southampton and my role is considerably different, consisting of:

- Male and female urinary catheterisation
- Insertion of arterial lines and peripheral cannulation
- Surgical first assisting
- Saphenous vein harvesting
- Leg wound closure using multi-layer closure and insertion of drain system
- Multi-layer closure of sternal wound
- Cardiac operating list co-ordinator support

Since commencing work at BUPA Southampton 9 months ago there have been many changes to my role. Currently, I am the only SCP, having taken over the role from the previous cardiac assistant 5 months ago. I now work solely in the theatre department and this has given me the opportunity to improve my surgical skills and become more confident in my surgical role. Presently, I have very little input in the care of the patient on the wards but as this role evolves this, I hope, will change.

In my SCP role I am currently implementing two new projects:

- Minimal access saphenous vein harvesting using the Mayo vein stripper
- NAASP Advanced Surgical Practitioner Course (for trained members of staff)

The past three years have been extremely interesting and rewarding.

The SCP coursework was often difficult to maintain due to the generic makeup of the course. Working fulltime in a specialist area meant that secondment to other surgical areas was onerous and often met with a degree of animosity from my colleagues. The surgical skills taught in house were thorough and to an extremely high standard and I was given support at all times.

Now that my initial training is complete I look optimistically to the future and the growth of this new SCP role. I would encourage other nurses to look seriously at this alternative and potentially very rewarding career path.



Delay in the Election of New Executive Members

James Roxburgh, Honorary Secretary

The process for this normally starts each November so that the successful candidates can be announced at the ABM. However this year, the process will be postponed until after the ABM when the new Executive structure and representation mechanisms have been debated and approved. As you will be aware from the paper presented by Graham Cooper the election process for the Executive members is one of the major points up for discussion. The executive therefore agreed that the election should be postponed until after the ABM. The election will follow very soon after the ABM and the new Trustees will, I hope, be in place before the first Executive meeting after the ABM.

A proposal to improve the SCTS Executive

Graham Cooper

Chair Working Group to Review the Constitution and Working of the Executive

The working group was established in January 2004. Using the responses to a membership questionnaire completed in 2004 the members of the working group and its reference group have developed the following proposal. This will be put before the Annual Business meeting in March 2007.

We have established that communication between the membership and Executive requires strengthening in both directions. In addition we have identified the key areas for SCTS. These are shown in table one, all are equally important. To improve communication and address the key areas we propose to modify the structure of the Executive and form a new representative body.

The new Executive will be smaller than the current Executive (table 2) and will meet quarterly. Each member of the new Executive will have responsibility for a key area:

- President
- President Elect
- Treasurer - Finance
- Secretary - SCTS Administration
- Meeting Secretary - Annual Meeting
- Communication Secretary -
New post (current Publications Secretary). Responsible for Bulletin, Website and developing electronic communication.
- Training and Education Secretary
Training and Education

Professional issues, Governance and Promotion will be divided between President, President Elect and Secretary. The 6 elected Trustees will have specified responsibilities. These are likely to include representing specific interests, eg thoracic

surgery, and taking responsibility for key areas under the direction of the relevant Officer. The specified responsibilities will be defined prior to election so candidates will know what is expected of them should they be elected. When necessary, working groups and/or sub-committees will be convened for specific projects. These will have Terms of Reference and a defined life span. The key areas and responsibilities will be reviewed at start of each Presidential term. The current Chair of SAC, Cardiothoracic Tutor, Chair Intercollegiate Exam Board, Young Consultant Representative will remain on the Executive until their terms expire. Their replacements will sit on the representative body.

The function of the representative body is to guide strategy for SCTS, to improve communication between membership and Executive and to provide a cohort of people to take part in working groups and sub-committees. It will build on the success of the Audit Leads Meeting. There will be a representative from each unit, it is envisaged that this person will have a defined term of office and be selected by the consultants in the unit they are representing. The representative body will meet twice yearly. Executive members will present a brief report and be open to questions from the representatives and key issues will be debated.

There are of course many areas of detail that require further thought, for example:

- What should the representative body be called?
- What is a Unit?
- Is it a Trust or a geographical site?
- Does it have a minimum size?
- Could the Unit Representative be a non-surgeon?

A proposal to improve the SCTS Executive continued

- Should all officers and elected trustees have job descriptions?
- Should officers and elected trustees be replaced early if they do not carry out the function described in such a job description?
- Should elected trustees be selected by a first past the post ballot or single transferable vote?

Any comments on this proposal or the points above would be most welcome. I am grateful to all those who have already taken the trouble to comment and look forward to debating this further in March next year.

- Communication
- Finance
- Annual meeting
- Governance
 - CCAD
 - Reaccreditation Guidelines
- Training and Education
 - SAC liaison
 - Exam
 - Advice to trainees
 - Scholarships
- Professional Issues
 - Job planning
 - Member support
- Promotion of Cardiothoracic Surgery
- Professional relationships
 - Lay and patient involvement
 - Non-medical staff involvement
- SCTS Administration

Table 1 Key areas for SCTS

<u>CURRENT EXECUTIVE</u>	
<i>President</i>	<i>Chair of SAC</i>
<i>President Elect</i>	<i>Cardiothoracic Dean</i>
<i>Treasurer</i>	<i>Cardiothoracic Tutor</i>
<i>Secretary</i>	<i>Chair Intercollegiate Exam Board</i>
<i>Meeting Secretary</i>	<i>Young Consultant Representative</i>
<i>Publications Secretary</i>	<i>Trainee Representative</i>
<i>6 elected members</i>	<i>Nursing Representative</i>
<u>NEW EXECUTIVE</u>	
<i>Trustee Members</i>	<i>Non-Trustee Members</i>
<i>President</i>	<i>Training and Education Secretary (was Dean)</i>
<i>President Elect</i>	<i>Trainee Representative</i>
<i>Treasurer</i>	<i>Nursing Representative</i>
<i>Secretary</i>	<i>Lay Representative</i>
<i>Meeting Secretary</i>	<i>Communication Secretary (was publication secretary)</i>
<i>6 elected members</i>	

Table 2 Current and New Executive

New Appointments

Name	Hospital	Starting Date
Karen Harrison-Phipps	Guy's Hospital	July 2006
Andrew Chukwuemeka	St Mary's Hospital	January 2007
Aman Coonar	Papworth Hospital	July 2007
Mike Shackcloth	Liverpool	January 2007

Other appointments

Name	Hospital	Starting Date	Appointment
Catherine Sudarshan	Papworth Hospital	September 2006	Locum Consultant



ANNUAL MEETING 2007

Graham Cooper, Meeting Secretary

The 2007 Annual Meeting will be held at Manchester International Convention Centre between Sunday 11th March and Wednesday 14th March. This is a superb, modern venue with excellent facilities. There is a wide range of hotel accommodation within easy walking distance. Registration will be open from 1st December 2006 and will be online only. Log on to www.scts.org and follow the links.

International guests are:

- **Keith Naunheim**
Chief of Cardiothoracic Surgery, Saint Louis University Hospital, Saint Louis, USA
- **Fred Grover**
Professor & Chair, Dept of Surgery, Colorado University, USA
- **Dirk Van Raemdonck**
Thoracic Surgeon in Leuven, Belgium and General Secretary Elect of The European Society of Thoracic Surgeons

Keith Naunheim and Fred Grover will deliver the Pulse and Heart Research UK lectures respectively as well as taking part in the St Jude Post Graduate sessions. Dirk Van Raemdonck will take part in the thoracic surgical session on Wednesday. We received very positive feedback about the Clinical Practice sessions introduced last year and will be featuring these again this year. In addition we are introducing digital presentations, these will be displayed on plasma screens in the Exhibition with presenting authors available during the breaks in the programme to answer questions. In addition on Wednesday we have separate congenital and thoracic sessions. The thoracic session will be another novel format. Titled 'What would you do?' It will consist of 5 presentations of difficult or interesting clinical cases. Each case will be presented for up to 5 minutes without revealing the outcome but ending with the question 'What would you do?' There will then be 10 minutes discussion between a panel of experts and the audience.

The Forum for Cardiothoracic Practice will run through Monday to Wednesday with Monday being programmed for database managers and the following two days for clinical staff. We have increased the number of joint sessions between the Forum and Clinical Meeting and as last year hope to see delegates visiting both Forum and Clinical sessions when they are running in parallel.

Wednesday evening will be the Annual Dinner when medals will be awarded to last year's prize winners and this years prize winners will be announced. The dinner will be at Old Trafford Football Stadium and will be preceded by a reception in the Manchester United Museum along with a stadium tour. Sir Bobby Charlton will be our guest and will speak after dinner. We have booked a small table for two at Maine Road for the evening, if anyone else would like to join Chris Munsch and Ian Wilson please let Isabelle know.

This will be the sixth and final meeting that I have organised for the Society. It has been an exciting time and we have made huge progress in improving the credibility, accessibility and stature of the meeting. The abstract assessment process that we developed has been adopted by EACTS and abstracts submitted have increased from 184 to 256 in 2006. We have broadened the ways in which research is presented to include Clinical Practice and Digital presentations. Delegate numbers have increased from 254 to 343 last year. The Forum for Cardiothoracic Practice has been introduced and expanded from one to three days. The trade exhibition has increased by 50%. None of this would have been possible without the commitment of Isabelle Ferner, Rachel Woolf, Rob Lamb and Simon Kendall.

Finally I would like to thank all of you who have attended the meeting over the past few years for your support.

I wish Simon and David Taggart good luck for 2008 and beyond.

Registration will be open from 1st December 2006 and will be online only. Log on to www.scts.org and follow the links

Entire Meeting attendance

Memb Category	Early	Late Til 12/1/07	Onsite Til 02/03/07
Member	£220	£295	£370
Non-member	£320	£420	£520
Non-medically qualified practitioner	£200	£275	£350

Day attendance

Memb category	1 Day	2 Day	CT Forum
Member	£140	£290	n/a
Non-member	£220	£450	n/a
Non-medically qualified practitioner	£120	£250	£75 per day

If you have any questions regarding registration or about the meeting itself, please contact Isabelle Ferner in the Society Office at sctsadmin@scts.org or by telephone at 020 7869 6893.

We look forward to welcoming you in Manchester

AGM 2007 Programme - Manchester ICC

Sunday 11th March

12.00 - 13.00	Trainees Lunch
13.00 - 14.00	Trainees Meeting
14.00 - 14.30	Intercollegiate Exam - Leslie Hamilton
14.30 - 15.00	Curriculum and on-line log book - Chris Munsch
15.00 - 15.30	PBAs and the new assessment process - Steve Hunter
15.45 - 16.00	Tea and Coffee
16.00 - 16.30	Cardiothoracic Training: The Effect of the European Working Time Directive Doug West
16.30 - 17.00	TBC
17.15 - 18.00	Teaching Complex Skills in a High Risk Environment Terry Hubble, Mountain Instructor
18.00 - 19.30	ABM1
19.30 - 20.30	Welcome Reception

Monday 12th March

	Clinical Meeting	Forum for Cardiothoracic Surgical Practice	Digital Presentations
09.00 - 10.00	Session 1 (Oral)		Cardiac and Thoracic
10.00 - 10.45		Tea & Coffee	
10.45 - 11.45	Session 2 (Poster)	Database managers	
11.45 - 12.30	Heart Research UK Lecture Fred Grover		
12.30 - 13.45		Lunch	
13.45 - 15.15	UK Activity and Practice		
15.15 - 16.00		Tea & Coffee	
16.00 - 17.00	Session 3 (clinical practice including transplantation)		
17.00 - 18.00	St Jude 1: (thoracic) Keith Naunheim		



AGM 2007 Programme - Manchester ICC

Tuesday 13th March				
	Clinical Meeting	Forum for Cardiothoracic Surgical Practice		Digital Presentations
09.00 to 10.00	Session 4 (Oral ombined forum and clinical meeting)			Cardiac and Thoracic
10.00 to 10.45	Tea & Coffee			
10.45 to 11.45	Session 5 ((clinical practice, including thoracic)	Forum		
11.45 to 12.30	Pulse Lecture Keith Naunheim			
12.30 to 13.45	Lunch			
13.45 to 15.15	Symposium: Revalidation			
15.15 to 16.00	Tea & Coffee			
16.00 to 17.00	Session 6 (clinical practice including thoracic)	Forum		
17.00 to 18.00	St Jude 2: (cardiac) Fred Grover			
Wednesday 14th March				
	Clinical Meeting	Forum for Cardiothoracic Surgical Practice	Congenital Meeting	Digital Presentations
09.00 to 10.00	Session 7 (Oral including) congenial and thoracic	Forum		Cardiac and Thoracic
10.00 to 10.45	Tea & Coffee			
10.4 - 11.45	Thoracic Surgical Session Dirk Van Raemdonck	Forum	Congenital Meeting What is the best conduit for the RVOT as homografts become less available? Who should do the ACHD work, and where? How should the training of SPRs in paediatric cardiac surgery be structured?	
11.45 - 12.30	Tudor Edwards Lecture 'Moving with the times: from 1967 to 2007 in cardiothoracic surgery' Tom Treasure			
12.30 - 13.45	Lunch			
13.45 - 14.15	President's Message	Forum		
14.15 - 15.15	Session 8 (poster, including congenial and thoracic)			
15.15 - 15.45	Tea & Coffee			
15.45 to 17.00	ABM2			

produced by Samer Nashef

Meeting: Focus on Congenital Cardiac Surgery, 4th International combined live symposium approved by EACTS, Co-organised by Deutsches Herzzentrum München, Herzzentrum Leipzig, Great Ormonds Street Hospital
Date: 14-15 December 2006
Venue: Munich, Germany
Contact: Trendhouse EventMarketing GmbH, Mrs. Astrid Schormann
Phone: +49 (0)89-368 498-0
E-mail: a.schormann@trendhouse.de

Meeting: Aortic Surgery "How to do it" II
Date: 15-16 December 2006
Venue: Aula Caravella S. Maria San Raffaele Congress Centre, Milano, Italy
Contact: Organising Secretariat, San Raffaele Congress Centre
Phone: +39 02 2643 3700
E-mail: aortic.surgery@spr.it

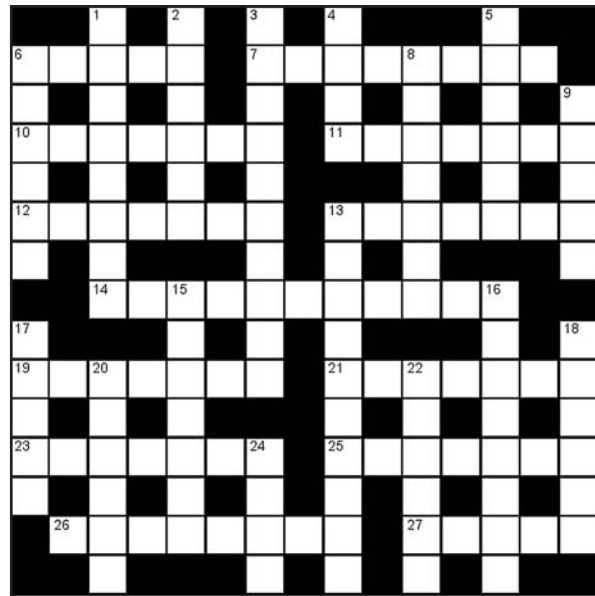
Meeting: Valve Technology Symposium
Date: 18 - 19 January 2007
Venue: St Geroge's Hospital, London
Contact: Frances Williams
Phone: +44 (0) 20 8725 3565
E-mail: fwilliam@sgul.ac.uk

Meeting: 43th Annual Meeting of The Society of Thoracic Surgeons
Date: 28 - 30 January 2007
Venue: San Diego Convention Center
Contact: The Society of Thoracic Surgeons
Phone: 1 312 202-5800
E-mail: sts@sts.org

Meeting: Society for Cardiothoracic Surgery in GB & Ireland Annual Meeting 2007
Date: 11 - 14 March 2007
Venue: Manchester International Convention Centre (MICC)
Contact: Isabelle Ferner
Phone: +44 20 7869 6893
E-mail: sctsadmin@scts.org

Meeting: The American College of Cardiology 56th Annual Scientific
Date: 24 - 27 March 2007
Venue: Morial Convention Center
Contact: ACC
Phone: 202 375-6000, Ext. 5603
E-mail: acc@itsmeetings.com

Meeting: 87th Annual Meeting - American Association for Thoracic Surgery
Date: 5 - 9 May 2007
Venue: Washington DC Convention Center
Contact: 900 Cummings Center,
Phone: 978-927-8330
E-mail: http://www.aats.org/annualmeeting



Across

- 6 Warning signal in the style of the marines (5)
- 7 Man prone to be minister (8)
- 10 A form of line art seen in toilet (7)
- 11 More even praise (7)
- 12 Serious audience at home (7)
- 13 Slim and profligate, a pound for a penny (7)
- 14 The 4,17 watching the 4, 6dn, 27, 4, 26, by the 4,5 (numbers game) (11)
- 19 4,5 loch? He saw it happen (7)
- 21 Bush, removed from office, returned (7)
- 23 Nice kit in motion (7)
- 25 From Dakar, a Chinese city in Asia (7)
- 26 Killed racehorse backed by journalist (8)
- 27 Living creature (5)

Down

- 1 Care a bit about bugs (8)
- 2 I swing both ways, live and drink (6)
- 3 Model sits nicest for no artists (10)
- 4/5 Ted may be simple (4,6)
- 6 Not 17, please! (6)
- 8 Articles from dodgy dealers (7)
- 9 Sounds like real caviar in Cornwall (5)
- 13 Fish jokes, boys and girls (10)
- 15 Prevented state 4,5 (7)
- 16 An empty air, elegant and wild (8)
- 17 Conscious of a slipstream (5)
- 18 Sport is King! (6)
- 20 Some put on guest language (6)
- 22 Idols after heart beats (6)
- 24 Port stopper (4)

This issue's crossword first appeared in the Papworth Newsbeat bulletin. Solvers whose postcode is outside a 20-mile radius from Papworth Hospital will therefore have priority when prizes are decided. The prizes will be given to two correct solutions to be chosen at random from those received by the deadline of 1 February 2007. Fax to 01480 364744 or mail to S A M Nashef, Papworth Hospital, Cambridge CB3 8RE

Last issue's solution



Edited by Sunil Ohri, Publishing Secretary **Contact:** sunil@ohri.co.uk

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