

the **bulletin**



Society for Cardiothoracic Surgery
in Great Britain and Ireland

July 2011

Annual Meeting London 2011

SCTS University

Quo Vadis Cardiothoracic Anaesthesia?

Advances in TAVI

The SCTS serves WHO first?

The Demise of A Thoracic Surgical Service

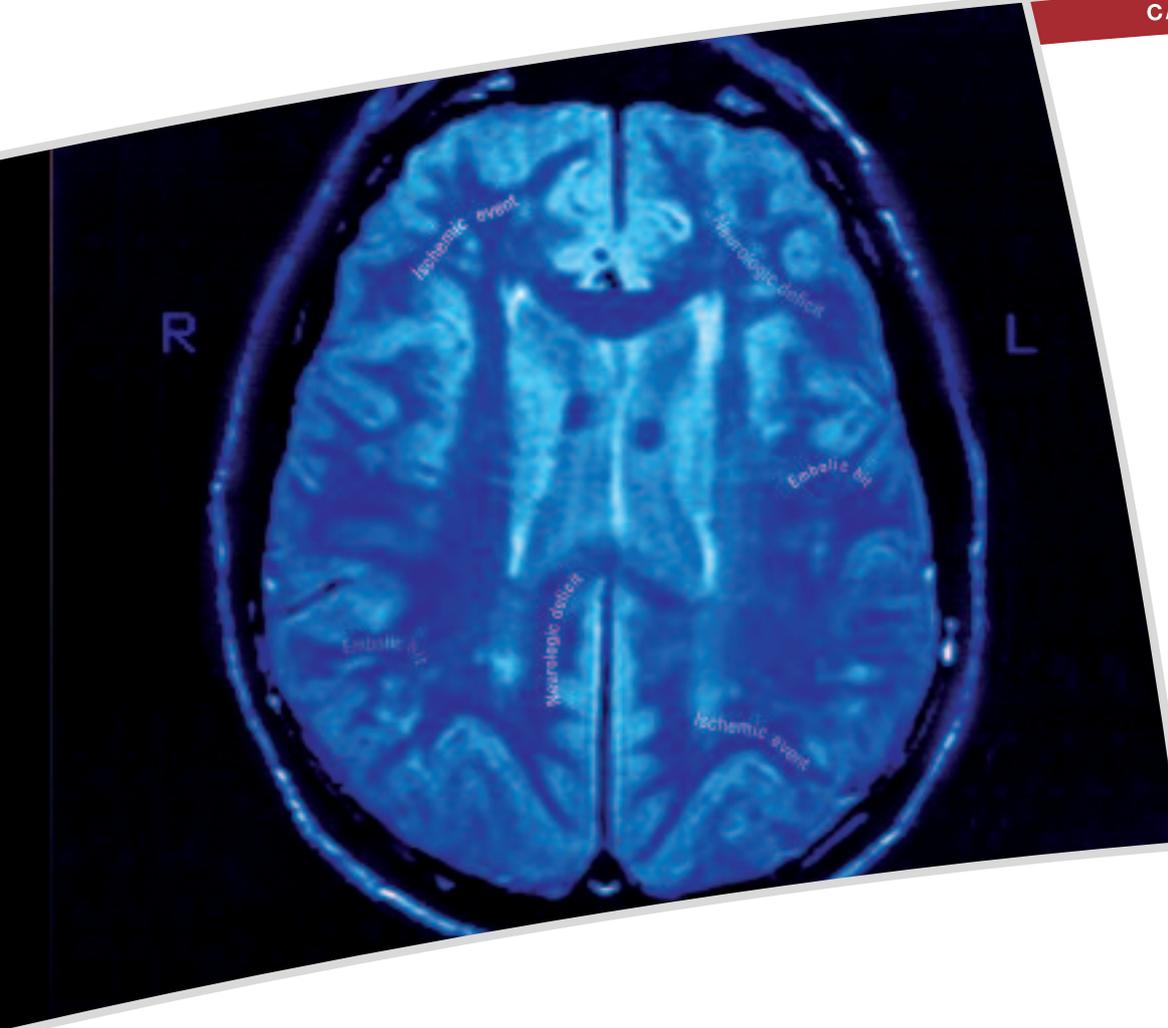
The SCTS response the NICE Guidelines

Patrick Magee
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1. Royse AG, Royse CF. Epi-aortic ultrasound assessment of the aorta in cardiac surgery. *Best Pract Res Clin Anaesthesiol.* 2009 Sep;23(3):335-41.
2. Hilker et al., Minimizing the risk of perioperative stroke by clampless off-pump bypass surgery: a retrospective observational analysis. *Journal of Cardiothoracic Surgery* 2010, 5:14

From the Editor's QWERTY 3

Vipin Zamvar Publishing Secretary

This issue of the Bulletin is tinged with sadness. Pat Magee passed away in May. To many in our Society he was a friend, mentor, trainer. He meant a lot to many people. To me he was a well-wisher, who provided a lot of support during my trainee years, and then especially when I was looking for a Consultant job at the end of my training. Many have offered to write remembering him, and we have an Obituary on page 7. There is also a photoboard with photos spanning his entire life. He will be sorely missed.

As always this Bulletin has reports from the office bearers of our Society, updating us on what's happening. Many have also come forward with articles they wish to share with colleagues. Hopefully, this trend will continue, and this Bulletin will be a forum for all to share their views (on any topic under the sun).

Over the last few years we have reviewed educational courses in this Bulletin. From the next issue we will also start reviewing books. If you have read an interesting book (medical or not) recently and would like to share your thoughts, please write a review for the Bulletin.

We all have other interests and if you or your colleagues have done something recently that you are proud of please let us know, and via this Bulletin we will let everyone know. In our inaugural "Other interests" column (page 35), we feature Sam Nashef, Rob Lamb, and Shyam Kolvekar. The Edinburgh Chess Club (the oldest in the world) annual championship is on, and I am through to the third round. If I progress any further I will let you know next time.



Have a relaxing summer break, and do please send in your articles. There are no deadlines, just send them to Isabelle at the Society Office, or to me whenever you are ready.

Vipin Zamvar

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Report from The President

I start this report with a heavy heart having just learnt of the death of Mr Patrick Magee. Pat was one of the best respected cardiac surgeons in the UK and held in the highest regard by all who knew him. He was a clinician who genuinely cared about his patients, expressed great interest in trainees and was never scared of being on the side of the underdog. Although not a traditional academic Pat showed great interest in research and was very supportive of my studies, intellectually and financially, when I was his Senior Registrar at the London chest Hospital. Politically he was one of the most shrewd men I have come across and I frequently sought his advice on complex issues; his exceptional wisdom was matched by great commonsense and he always acted with the highest degree of integrity. As President of SCTS he exhibited these talents effortlessly and in abundance and was a great champion and ambassador of our Society. His untimely death is a real loss to all who knew him and in particular SCTS. Our thoughts are with his wife Patricia and family.



It is difficult to believe that already the first year of my Presidency has already passed. And this last year witnessed a number of very important highlights which will largely determine the future of our specialty. First, and on an optimistic note, was the production of the "Lilac Book" outlining SCTS's view of contemporary medical

professionalism which not only reinforced currently well established concepts such as publication of outcome data but also discussed a number of other possibilities for the future including continuing professional development, measuring patient experience and multi-source feedback. I have to acknowledge a

tremendous amount of work and initiative by Ben Bridgewater in pushing this project forward and with considerable assistance from Graham Cooper and many others including James Roxburgh, Malcolm Dalrymple-Hay, Steve Livesey and Raj Shah who wrote several of the chapters as did a number of external experts. I am very

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Professor D P Taggart, MD, PhD, FRCS

aware that several of these issues can appear challenging and unsettling but so was the publication of outcome data more than a decade ago. Furthermore, we live in a society which increasingly demands transparency. The public and profession want access to health outcomes in a similar way to having access to expense claims of MPs. It is this kind of initiative which has promoted the influential position of SCTS within the profession and political circles and was in no small measure partly responsible for the appearance of the Right Honourable Andrew Lansley MP, at our annual meeting. This was the first appearance of the Secretary of State at an individual medical society conference.

Another optimistic development is the increasing resection rate for lung cancer almost certainly due to a marked increase in thoracic surgery consultants over the last few years. However there are still marked discrepancies in the resection rates in different areas and

The increasing resection rate for lung cancer almost certainly due to a marked increase in thoracic surgery consultants over the last few years.

the potential reasons are being explored through thoracic data collection submitted to the National Lung Cancer Audit. SCTS is currently looking for funding to support the thoracic database. I was also very struck at the thoracic forum, organised by Alan Kirk in Glasgow last year, by the strong support for SCTS as a whole and a general recognition that we really are much stronger together than as separate and smaller specialities. However, there is also increasing recognition within SCTS that we need to have more thoracic surgeons on the Executive and consequently it was therefore agreed to support an initiative from the thoracic forum that in addition to the two recently elected thoracic representatives (David Waller and Rajesh Shah) the organizer of the next thoracic forum would join the Executive albeit in an initially non-voting format. With John Duffy still acting as the chair of the thoracic surgery sub-committee this produces a powerful thoracic line-up.

Another important initiative within the last year was the publication of the ESC/EACTS Guidelines on Myocardial

Revascularisation. These Guidelines are very important not only in ensuring that patients have access to the best treatment options but also for our speciality. Consequently I believe cardiac surgery is currently at a critical crossroads and that whether we thrive or decline will depend on whether the Guidelines are actually implemented. If we fail then we not only do our patients a disservice but the outlook for cardiac surgery will become more precarious because the tendency for some interventional cardiologists to treat patients with either stents or with percutaneous valves will become increasingly common even if this is not always the best treatment for the patient and is not supported by an appropriate evidence base. For example, it is especially notable that in Germany last year one third of all aortic valves were done percutaneously without reference to multi-disciplinary teams or guidelines. In particular SCTS were extremely concerned with the initial version of the proposed NICE guidelines on stable angina which recommended that a cardiologist could treat any severity of coronary artery disease if they considered 'the anatomy suitable' and without reference to the multidisciplinary team. SCTS responded robustly (see letter) stating why it would not support these proposed guidelines and David Geldard our patient representative wrote to NICE regarding their apparent undermining of the MDT. Encouragingly, the revised NICE proposals are much more balanced in their recommendations for stents vs surgery and now accept the importance of the MDT.

For our paediatric colleagues there is still uncertainty regarding the final reconfiguration of these services while the situation for transplant centres also continues to evolve. That there needs to be rationalization of these services is beyond dispute although there is still vigorous debate over the final resolution.

Finally, I would like to acknowledge the outstanding efforts of Simon Kendall, Ian Wilson and Tara Bartley in organising the annual meeting. I am privileged to have had the opportunity to attend many cardiac surgery and cardiology meetings over the last few years and I can say without any exaggeration that the quality of the last SCTS meeting was truly outstanding both in its academic content and in its social events. Ian Wilson's and Raj Shah's organisation of the SCTS University within the meeting was absolutely outstanding and one of the highest quality programmes I have ever attended. The highlight of the social event was the River Thames cruise and I personally was delighted and honoured to be able to give Professor Sir Magdy Yacoub, to whom I was a senior registrar, his Lifetime Achievement Award, after an excellent tribute by John Pepper.

David Taggart, President

Honorary Secretary's Report

Graham Cooper

Our Annual Meeting this year was once again a triumph; The SCTS University was outstanding and significantly impressed our international faculty. The breadth of papers presented was even greater than at previous meetings. We were able to listen to an impressive range of speakers, including the Secretary of State for Health.

Whilst it was interesting listening to him and he was positive about SCTS, that he accepted our invitation to speak is also important. We used this opportunity to launch the Lilac book 'Modern Medical Professionalism'. This has made a substantial impact. Neither of these things, in themselves will change the way we practice tomorrow but they do contribute to ability to promote professional values and influence.

One area where we will use this influence is commissioning. The mechanism for commissioning of cardiac and thoracic surgery in the future is an issue that will change the way we practice in the near future. It is unclear, as I write this, how the healthcare that we provide will be commissioned. The NHS Listening Exercise closed on 31st May and the outcome of this will influence the shape of the Health and Social Care Bill following the pause in its passage through Parliament. A few principles seem likely to remain. The National Commissioning Board will directly commission some services and hold to account consortia for the services they commission locally. The focus is likely to be on outcomes rather than process measures. Quality Standards developed by NICE will form the basis upon which services are commissioned.

As far as I understand within cardiothoracic surgery, transplantation and paediatric surgery will remain nationally commissioned, adult cardiac surgery may be nationally commissioned and thoracic surgery will be locally commissioned. This is an area that clearly calls for professional input and we are developing our ideas about how this is best provided. We will be drawing up commissioning guidance for adult cardiac surgery and thoracic surgery, transplantation and paediatric surgery are already covered. The Royal College of Surgeons of England has defined seven principles for commissioning:

1. **Training the healthcare workforce:** a contractual commitment to training and the ability to deliver the standards and outcomes agreed and published by the professions.

2. **Educating the healthcare workforce:** a contractual commitment to provide appropriate education and continuing professional development opportunities for all health professionals.

3. **Clinical audit contractual agreements:** to ensure participation in clinical audit and publication of audit outcomes.

4. **Research and development contractual agreements:** to ensure participation in high quality research which is essential for advancing and improving patient care and outcomes.

5. **Commissioning a complete service:** ensuring the service includes arrangements for full emergency provision at the appropriate level. There must also be proper follow-up and a commitment to dealing with long-term complications and carrying out revision surgery.

6. **Measuring outcomes:** to be measured coherently to enable comprehensive benchmarking across the NHS, with the data made available to the profession and used to inform practice and improve patient safety.

7. **Appropriate impact on the local healthcare economy:** when commissioning a service, a full assessment must be made of the impact of the decision on existing patients pathway of care in order to safeguard patient access.

These will guide the guidance that we draw up. We would like to hear from anyone wishing to contribute to this process and especially anyone who is already working on this locally.

To ensure the guidance is implemented we will need a national and local strategy. Locally we will rely on our unit representatives both to make the guidance locally relevant and to implement this.

We learnt that Pat Magee has passed away with great sadness. An obituary appears elsewhere in this Bulletin. His wisdom, sense of duty, dignity and unfailing consideration for others will continue to inspire me. The debt SCTS owes him for his strong leadership over many years is immeasurable and we are thinking of a suitable way of recognising this.



Patrick Gabriel Magee

Consultant Cardiothoracic Surgeon

Born 25th February 1947, Died 30th May 2011

Celebrities feel they have “arrived” when they are known to all by their first name – in our specialty we all knew who “Patrick” was - great family man, friend, colleague, mentor, role model and inspiration to many in Cardiothoracic Surgery and beyond....

Patrick Gabriel Magee graduated from University College Dublin with Honours MB, BCh, BAO in 1971 and went on to obtain a 1st Class Honours BSc in Anatomy and Physical Anthropology in 1973. He obtained his FRCS (Edinburgh and Ireland) in 1976 and FRCS England (ad eundem) in 1996.

He undertook his higher specialist training at Brompton Hospital, National Heart Hospital and The London Chest and The Royal London Hospital working with many of the renowned surgeons of that era. He also spent one year as a Fellow at Johns Hopkins Hospital in Baltimore. He became a Consultant Cardiothoracic Surgeon at The London Chest Hospital and The Royal London Hospital in 1982. He was also an Honorary Senior Lecturer in Cardiothoracic Surgery at The University of London from 1982.

Patrick contributed to many publications in leading international and national journals. His publications and presentations cover all aspects of cardiothoracic disease but particularly myocardial protection, coronary artery disease and its complications and, more recently, studies on the appropriateness of revascularisation. He supported clinical research and researchers and greatly enjoyed being a Council member for the British Heart Foundation.

Patrick undertook many of the big jobs in the specialty and was widely known nationally and internationally. He was President of the Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS) 2004 to 2006 and was on the Council of the Royal College of Surgeons of England. He was formerly President of the Cardiothoracic Section of the Royal Society of Medicine and President, Section of Cardiothoracic Surgery Union of European Medical Specialities (UEMS) 2004 to 2010. One of his greatest contributions was as Chairman of the Specialist Advisory Committee in Cardiothoracic Surgery and previously as Postgraduate Dean of the SCTS – a great involvement in training and education for the UK and Ireland from 1995 to 2002 - identifying and inspiring subsequent members and SAC chairs to date. He was a member of the Specialty Advisory Board for The Royal College of Surgeons of

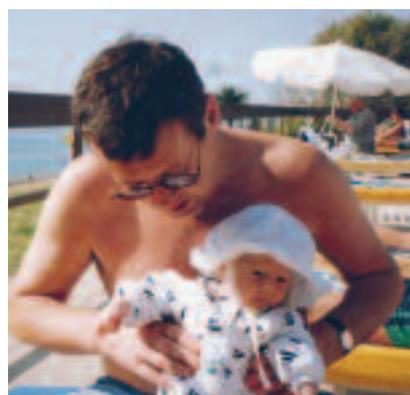


Edinburgh since 1999. He was a member of the Intercollegiate Exam Board in Cardiothoracic Surgery; an examiner since 1995 and more recently was responsible for Quality Assessment of the examiners during the examinations. He was Lead Examiner for the Tri-Collegiate Examination in Cardiothoracic Surgery of the Royal College of Surgeons Edinburgh, Academy of Medicine Singapore and College of Surgeons Hong Kong since its inception in 2003. Patrick was the David Chan Visiting Professor at the Chinese University of Hong Kong in 2005 and greatly enjoyed his visits to the Far East – always accompanied and minded by Patricia! He sat on and chaired many other committees and was well known for his diplomatic and organisational skills.

Above all though Patrick was a great bloke – approachable; humorous; kind and worldly wise. A great host and raconteur – he always brightened up any social occasion. He weathered two major episodes of surgery during his career and returned to full time working after both. Many of us have sought and been grateful for his advice and input into our careers over the years and he will be greatly missed – Patrick is a great loss to our specialty and his achievements and contributions should be recognised and celebrated.

Patrick leaves his wife Patricia and three sons Hugh, Cormac and Ronan to whom we extend our deepest sympathies.

Tim Graham, Leslie Hamilton, Graham Cooper



Annual Meeting 2011

LONDON EXCEL – Sunday to Tuesday, MARCH 20th – 22nd 2011

I tried to think of different ways to start this article, but having thought of some different options, it is clear to me that there is only one appropriate way: and that is to again thank each and every one of you who participated in this year's annual meeting.

Needless to say the meeting is a 'people thing' and without enthusiasm from delegates, speakers and corporate representatives none of it would be worthwhile, and hence the importance of saying thank you from all of us in the organising committee.

Isabelle's influence on worldly matters worked wonders again, with warm weather and blue skies accompanying our annual meeting. Some delegates for the SCTS University were initially drawn towards the body building congress, but the lure of excellent postgraduate education proved too much for them.

University

This year we made sure that the whole of the Sunday programme was dedicated to the university and avoided any of the parallel sessions that occurred in Liverpool. We will continue to make improvements year on year and for certain we will make sure that there are more educational streams in thoracic surgery.

The University programme is reported in Ian Wilson's article –it is astounding the amount of thought and work that he puts in to the project: this has gone from concept to reality in less than two years and is a credit to his dynamism.

We charge members £20 to reserve a place on the SCTS University, which we hope is recognised as exceptional value for money and is a tangible way that the society contributes to its membership.

The programme is usually finalised in early January, but this year was the exception. Only a few weeks prior to the meeting there were rumours that

the Health Secretary might be attending. Then with only a week to go an emergency Cabinet meeting was called and necessitated a further change to the afternoon programme. I am grateful how understanding everyone was under the circumstances.

Graham Cooper set the scene for Andrew Lansley's address, summarising the achievements of the society encapsulated in the society's freshly released book on Modern Medical Professionalism. The 700 seat auditorium was packed, with excess delegates having to stand at the back.

Health Secretary

Putting political persuasion to one side it was a major coup for our society that the Health Secretary should have chosen our speciality as the first to address. He was slightly caught off guard by David Taggart's introduction and reference to his stand against the Iraq war, before delivering a robust address, which was very complimentary to all the quality initiatives that our society has achieved.

As an MP from Cambridge he clearly had good knowledge of the Papworth unit and hence our speciality, and as he had not received the prepared questions prior to the meeting it was impressive how well he responded.

Prior to the Health Secretary's address there were several important parallel sessions;

The Database Managers had met for the 6th consecutive year. Tracey Smailes, Middlesbrough, has been the lead since it was first established and had organised a very relevant and interesting agenda. The role of data has been pivotal in promoting our society and the care of our patients and the database manager's forum has been vital in sharing good practice and achieving consensus. Understandably, but regrettably, Tracey has decided to step down from this role and we wish her well concentrating on 'the day job' in the knowledge she has made an outstanding contribution to the national agenda.

The Trainees Meeting, organised by Betsy Evans, Papworth, had a comprehensive agenda with presentations and discussion

on national selection, specialty exam, EWTD and service delivery. Another good turnout from the trainees rewarded by the presence of all the national leads in training.

Eric Lim had kindly brought **The Thoracic Surgical Research Collaborative** to the AGM – this is a biannual forum to propose, review and coordinate national research, which must be the optimal way to make the most out of the significant effort from patients and clinicians.

A lot of hard work had gone into the preparation of the **Patients' Forum** by our patient representative David Geldard. There were papers presented on admission and discharge, a presentation on cardiac rehabilitation by the national clinical lead, Jane Flint and the vision of future care from Sir Bruce Keogh and Tara Bartley.

ACSA (Association of Surgical Care Practitioners) held their annual meeting in conjunction with ours for the fourth successive year. They are playing a larger and larger part in the care of cardiothoracic patients, so much so that it is often difficult for them to be able to leave their units and attend while so many surgical staff are also in attendance. Their president, Toby Rankin, has had a very successful term in office but now has a more challenging role in Plymouth and is having to relinquish his post - it has been a pleasure to work with him and we are very grateful for his continued support of the meeting.

There continues to be debate on the role of surgeon specific results and the **Management of the High Risk Patient**. Graham Cooper had carefully considered this sensitive session and we were rewarded with presentations from Irving Kron (the US perspective), Ian Wilson (what's wrong with risk averse behaviour), Tim Jones (the Birmingham congenital model) and Steve Griffin's inspired insights into the personal and professional effect of 'managing divergence', the latter receiving a standing ovation.

The Cardiothoracic Nurses Forum had another outstanding two day agenda. Tara Bartley has consistently raised the bar



Simon Kendall Meeting Secretary

London 2011



Annual Meeting 2011 continued

year on year attracting national leaders to present, as well as an increasing number of abstracts and papers. The past president of the RCN, Maura Buchanan and the new president Andrea Spyropoulos were both present. Tara's contribution to the Forum, the Executive and the national agenda for cardiothoracic nursing is all done in her own time and her commitment and delivery of excellence has been recognised by the award of the rare and prestigious RCN fellowship, presented in May at the RCN conference.

This was the second year we held a **medical students' poster competition**. Expertly organised by David McCormack, there were an astonishing 42 submissions and the presenters are all given free registration. The judges selected 10 posters to be presented on the Tuesday lunchtime. On the Monday night the students organised a social (with some support from the Society) which apparently involved the bars including Kings' Students union and UCL – but too many others to list apparently.

The **Thoracic Surgical Programme** continues to expand. There were more parallel sessions than ever, compiled by Rajesh Shah, Sion Barnard and John Duffy: a total of 46 papers, two lectures, two symposia and the research collaborative. We welcomed **Professor Jean-Marie Wihlm** who presented on chest wall reconstruction and **Professor Rob McKenna** who gave the Tudor-Edwards lecture on lung volume reduction surgery.

In **Cardiac Surgery** we welcomed **Lars Svensson**, who gave his lecture on the role of Aortic stenting, **Michael Mack** debating the technology on sutureless aortic valves and **Irvin Kron** summarising contemporary mitral surgery.

Possibly the most contentious on going debate is the **reconfiguration of paediatric cardiac surgical services**. Dr Jeremy Glyde (project manager) and Dr Patricia Hamilton (chair of steering group) accompanied Roger Boyle (Heart Tsar) in brief presentations followed by discussion of the potential changes. Andrew Parry had organised a **congenital programme** that was stronger than ever: a corporate symposium on RVOT to start the day; discussion on reconfiguration; symposium

on complex transposition; paper presentations and finishing with a further symposium on bicuspid aortic valves.

Indeed the aortic valve was the focus of several sessions on the Tuesday: Vinnie Bapat had coordinated the TAVI symposium, Malcolm Dalrymple-Hay the Mini-AVR symposium and finishing with the session on the bicuspid aortic valve chaired by Sir Magdi.

Our President has been central to the debate on strategies for revascularisation. He has been most influential in the compilation of the **ESC / EACTS guidelines** with a writing group more balanced than ever before. The symposium on this subject was enriched by the presence of two of the major authors, Professor Kolh and Professor Wijns as well as the presidents of the Cardiac Society, Professor Keith Fox and BCIS, Dr Mark DeBelder.

EWTD – has this become a four letter word in surgery? It's certainly an area of contentious debate and appears to be affecting the amount of time for training, the continuity of care for patients as well as the cost of that care. Marjan Jahangiri coordinated a lively symposium including the President of the College of Surgeons, John Black, and the head of HR from the QE at Birmingham, Ms Rona Miller, to make sure we had the facts as well as the effects.

Annual Dinner

The meeting concluded with the annual dinner on a Thames river cruise – but not quite as we intended. The food was excellent (just as we had tasted back in January) the jazz music superb, the wine just right, but..... did we have the night time views of London's magnificent and historic landmarks? No! On boarding the Silver Sturgeon (not Surgeon) Isabelle and I were informed that the tides were going to prevent any journey up river, so we had to settle with a tour round the Isle of Dogs and multiple views of the Millennium Dome.

However we had a grand finale to enjoy: Professor John Pepper expertly presented an entertaining account of **Professor Sir Magdi Yacoub's** outstanding career and presented his Lifetime Achievement

Award. This is the fourth such award and, as with the previous three, there was a reverent silence as Sir Magdi spoke, giving us further insight to the great man.

We are fortunate to have such **strong corporate support**. Their continued focus on education is mutually beneficial to improve the content of our meeting and the opportunities for our patients. Tilly Mitchell had done a superb job attracting exhibitors and designing the exhibition hall, which opened earlier than usual with the Welcome Reception.

Last, but not least, and certainly the greatest thanks goes to **Isabelle Ferner** – I've said it before but she is the hub of the entire affair. She has an extraordinary ability to manage and communicate the multiple facets of the meeting, and its hard to imagine the chaos if she wasn't there to guide us year on year.

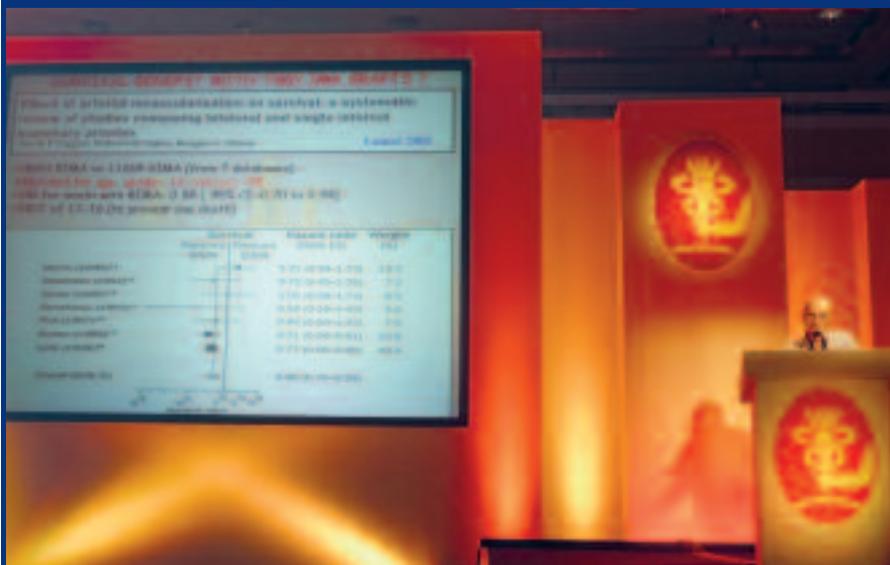
What makes a successful meeting? I think it might be when the participants leave and feel it has been worthwhile – worth the time, worth the expense. And this will be measured in many different ways: good to deliver a paper or talk; met old or new colleagues; learnt new practice or knowledge; met potential new customers; reinforced current practice; updated on current topics; the feeling there has been an opportunity to influence the agenda; new ideas for research or collaboration – the list goes on and we hope we can deliver to as many as we can.

Next year is a new era for the AGM - even though we are renamed the Society for Cardiothoracic Surgery (AND we couldn't possibly work without each other) we have yet to 'meet' with the Association of Cardiothoracic Anaesthetists ACTA. Therefore we are combining our meetings for the first time in Manchester, April 18th – 20th. The agenda will focus on common areas for the two societies and it may be that units will reduce their service to enable more colleagues to attend.

It should be a great meeting, and if so we might consider repeating the venture every three to five years. We hope you will come and take part.

Simon Kendall

London 2011



SCTS University

SCTS University 2011 represented the second phase in the development of the Society's postgraduate education programme; staged on the 20th March 2011 at ExCel, London, immediately prior to the SCTS annual meeting.

Pre-registration was high; over 290 delegates signing-up prior to the day, and with on-site registration, members of faculty and corporate participation over 450 attendees filled the Platinum Suite as the Medical Director of the NHS launched the event for the second year. A fantastic turnout at 08:30 on a Sunday morning.

Participants reflected the constitution of the Society's membership; 35% of delegates were consultant surgeons and 55% trainee surgeons, whilst ACSA members, Perfusionists and Forum members also enjoyed the vibrant educational environment created by the world-class faculty.

As the SCTS University programme was allowed to develop a full day's activity, an expansion from the first year's course, the stamina of both delegates and faculty was tested by a programme committee not willing to let an educational opportunity pass by.

SCTS UNIVERSITY

The day included 6 parallel Educational Streams, each of which analysed contentious areas of current cardiothoracic clinical practice within an exhaustive **6 hour interactive programme**. Delegates were encouraged to interrogate the national and international faculty, resulting in an energetic cocktail of education and experience.

The midday break was occupied by **7 parallel "Lunch Box" sessions**; 90 minute seminars of topical analysis and debate, exploring some of the most controversial areas within cardiothoracic surgery.

The dynamic atmosphere generated by delegates and faculty alike resulted in a

tremendously educational day, facilitated by the use of "Hands-On" models of contemporary clinical practice, "State of the Art" simulators, and "Minds-On" exploration of contentious topics within current day practice.

The Educational Streams in the SCTS University 2011 were:

- **Ischaemic Mitral valve Regurgitation: The Art of Balancing Forces**

Professor Irving Kron, University of Virginia, and Mr Frank Wells, led a vastly experienced faculty of international and national authorities in the field. The international faculty included Professor Jean-Louis Vanoverschelde, Professor Patrizio Lancellotti, Dr Patrick Perier, Mr Ani Anyanwu and Professor Malcolm Underwood; a national faculty complimented this international experience, resulting in a comprehensive review of the knowledge-base of this complex area of clinical practice, alongside a fascinating look into the future. The wealth of experience within the assembled faculty led to a most authoritative review of the subject data, in a style that allowed intense interaction with the enthusiastic delegates.

Average Session score: 4.50/5

- **Aortic Dissection: A Surgical Master Class**

Professor Lars Svensson, Cleveland Clinic, and Professor Bob Bonser, chaired a highly dynamic educational programme, supported by a hugely experienced international and national faculty. This Educational Stream offered the opportunity to gain a comprehensive "State of the Art" review of the many contentious topics within the clinical arena of Aortic Dissection surgery. International perspectives on the national configuration of Aortic Dissection

surgery service delivery proved insightful and may well assist in shaping the ongoing UK debate.

Average Session score: 4.40/5

- **Off-Pump Coronary artery Bypass Surgery: Understanding its role in 2011**

Professor John Puskas, Emory University, Professor Gianni Angelini and Professor David Taggart collaborated in creating a highly interactive programme examining the field of OPCAB surgery. The congregation of OPCAB enthusiasts and authorities in the field, alongside a collection of delegates hungry for knowledge, resulted in a vibrant atmosphere of exchanging data, tips, tricks and experience.

Average Session score: 4.56/5

- **Innovative Options in Aortic Valve Surgery**

Dr Michael Mack, The Heart Hospital Baylor Plano, Texas, and Mr Ben Bridgewater developed an intriguing programme analysing the evolution of aortic valve surgery, iterative changes in practice, risk prediction models, and how these models interact with decision-making in TAVI surgery. Professor Volkmar Falk, University of Zurich, Professor Thomas Walther, Kerchoff Heartcentre, Bad Nauheim, offered huge international experience and complimented a highly thought-provoking national faculty. "Hands-On" simulation models allowed delegates an ideal opportunity to reinforce the educational content of the session, offering practical experience in TAVI surgery.

Average Session score: 4.70/5

- **Contemporary Thoracic Surgery**

Professor Robert McKenna, Cedars Sinai MC, Los Angeles, and Mr Rajesh Shah led a dynamic Thoracic Surgical programme which proved so popular that the delegates had standing room only within a venue capable of seating over 90 attendees. This Educational Stream explored "State of the Art" minimally invasive thoracic surgical

Ian Wilson



approaches alongside exploration of specific complex clinical scenarios, including Post Pneumonectomy Empyema, Ruptured Oesophagus, Primary Malignant Chest Wall Tumours and Mediastinal Tumours. This highly interactive session generated huge interest and vibrant discussion.

Average Session score: 4.27/5

- **The Small Aortic Root: Meeting the Needs of Different Generations**

Mr Asif Hasan and Mr Marcus Haw co-hosted an Educational Stream encompassing the clinical dilemma of Patient-Prosthesis mismatch; its clinical relevance and how it can be managed. "Hands-On" reconstruction of aortic root enlargement techniques on human cadaveric hearts, courtesy of NHSBT – Speke, allowed detailed understanding of the relative merits of these procedures. The supervised "Wet Lab" experience, supported by Professor Marjan Jahangiri, Professor Mark Redmond, and Mr David Anderson, afforded an almost unique opportunity to gain increased understanding of the complexities of these reconstructive procedures.

Average Session score: 4.65/5

Although the change around at the lunch-break was a little hectic, overall the quality of the food was good and delegates settled into their chosen sessions with a bite to eat, and a drink at hand. Delegates assessed that the Lunch Box sessions were a good use of the lunch-break 4.4/5; encouraged by this we will look to replicate this format next year.

The 7 Lunch Box Sessions filled the lunch-break ensuring a lively interlude of contemporary discussion with the world

authorities gathered at ExCel within the SCTS University 2011.

These Lunch Box sessions included:

- **Endoscopic Conduit Harvesting: Unravelling the Myths**

Malcolm Dalrymple-Hay chaired a dynamic session in which Professor John Puskas and Dr Michael Mack explained how the PREVENT IV and ROOBY Trials influenced the evidence base, whilst Mr Tony De Souza and Mr Toufan Bahrami gave a robust response, detailing how endoscopically harvested conduit can be utilized in a progressive UK practice.

Session score: 4.33/5

- **Evaluation of Graft Patency:**

Valuable Quality Assurance or an Unnecessary Expense

Mr Philip Hayward led a fascinating session in which Professor David Taggart, Professor Thierry Carrel, Berne, Switzerland, Dr Teresa Kieser, Calgary, Canada, and Dr Roger Bury, Consultant Radiologist explored the role of establishing quality assurance after coronary artery bypass surgery and what this evaluation adds to the standard of clinical practice.

Session score: 4.50/5

- **Postoperative Bleeding: More Than Just a Lost Night's Sleep**

Professor Keyvan Karkouti, University of Toronto, and Mr Gavin Murphy, critically analysed the evidence-base within the clinical arena of postoperative bleeding with outstandingly insightful detail, whilst defining optimal peroperative management strategies to facilitate haemostasis in this field of rapidly changing emphases.

Session score: 4.32/5

- **Minimal Extracorporeal Circulation (MECC) or Retrograde Autologous Prime (RAP):**

What Role in Contemporary Cardiac Surgical Practice?

Contemporary perfusion techniques were evaluated in a session chaired by Mr Mo Bhabra and Mr Steve Robins

which explored the role, safety and efficacy of MECC and RAP, including a description of how these novel techniques can be incorporated into clinical practice to optimise CPB safety and augment patient protection.

Session score: 4.60/5

- **Guidelines in Lung Cancer Management and Resection: Utility of Futility**

Professor Alessandro Brunelli, Ancona, Italy, Mr Richard Page and Mr Eric Lim, explored the current national and international guidelines, debating how the NICE Guidelines on Lung Cancer Management influence clinical practice, whilst analysing the European and BTS / SCTS Guidelines in Lung Cancer Resection; evaluating how these guidelines may be used to increase UK resection rates.

Session score 4.29/5

- **Emerging Technologies Workshop:**

Mr Joe Zacharias chaired a frantic session exploring some of the most progressive areas of clinical practice which included; an Endobronchial approach to Emphysema and prolonged air leaks (Mohammed Munavvar), What every Mitral surgeon needs to know of the Everest trials (Irv Kron), Short and long term ventricular support in a non transplant setting (Christian Schlensak, Freiberg), Future directions for cardiac surgery: A Cleveland Clinic perspective (Lars Svennson), State of the Art Sternal Closure: Primary and Secondary (John Dunning). Joe did a great job holding together such a diverse group of topics delivered by an assembly of world authorities.

Session score: 4.28/5

- **Hybrid Interventions are the Future of Congenital Cardiac Surgery**

Mr Tim Jones chaired a debate evaluating the future development of congenital cardiac surgery, as the role of minimally invasive surgery and percutaneous techniques evolve; Dr Shakeel Qureshi took the cardiological viewpoint, whilst Mr David Anderson took the surgical stand, outlining how

SCTS University continued

current technologies can enhance the therapeutic options available in the management of this potentially complex group of patients.

Session score: 4.50/5

All Educational Streams and Lunch Box sessions were augmented by a Literature Review which was printed within the programme; this effort unquestionably proved to emphasise the content of the individual sessions. Many thanks to all contributors; Neil Roberts, Aaron Ranasinghe, Neil Howell, Paul Modi, Steve Woolley, Ben Davies, Nigel Drury, Vanessa Rogers, Vassilios Avlonitis, Haris Bilal, Donna Eaton, Phil Botha and Tom Barker .

The SCTS University ended at 17:00, with a positive air generated and maintained throughout the day. The interactive format of the programme undoubtedly afforded the opportunity for delegates to get "close and personal" to world authorities in their field and benefit from their knowledge and experience.

On behalf of everyone involved in the programme I would like to express thanks

to all the faculty involved this year. The quality of the international and national faculty was extremely high, which resulted in a very high calibre and successful meeting this year.

The untiring support, both mentally and physically, from Simon Kendall, Rajesh Shah, Tara Bartley and Christina Bannister, in delivering the educational programme is enormously appreciated and last but not most important Tilly Mitchell and Isabelle Ferner's unflinching execution of the proposals forwarded have been instrumental in the achievements accomplished this year.

We would also like to express enormous gratitude to all the corporate groups who supported this initiative. Without such support this venture could never have got off the ground, and we really appreciate the ongoing assistance as the project matures.

Part of this maturing process has seen the launch of the SCTS University Ethicon Surgical Scholarships this year, which include potential educational

opportunities in New York, Hong Kong, Singapore, Atlanta, and Rennes, alongside other national and international venues. These four, six month fully salaried Scholarships, including travel expenses, will be awarded in June 2011 and will offer an amazing opportunity for senior trainees in the style of a "Finishing School" in subspecialty areas of clinical practice. Many thanks to Ethicon for making these Scholarships available to cardiothoracic trainees in 2011.

The construction of SCTS University 2012 is underway. If members have ideas that they would like to explore for SCTS University 2012 or 2013 please contact me: Ian.C.Wilson@uhb.nhs.uk. Recognising the demand for Thoracic Surgical content within the project, SCTS University 2012 will increase Thoracic Educational Streams.

The SCTS University project is designed by, and delivered for, the SCT membership in its broadest definition, and we hope that you will want to participate as both faculty and delegates in the years to come.

Cardiothoracic Dean's Report

Sion Barnard Cardiothoracic Dean

The first 6 months of this year have probably been the busiest for the Cardiothoracic Dean.

As well as my normal day to day work as a Thoracic Surgeon I contributed to the Thoracic forum in Glasgow, which was well attended, including the President of the Society who contributed to the debate on training for Thoracic Surgeons. In addition, late March was a busy time with preparation for the Society meeting and the University which was very successful. The Trainees day was very well attended and as usual there were a number of questions regarding National Selection. The trainees who had been through or were about to go through the selection process, were invited to submit concerns and areas for improvement to the process. Two weeks later the 2011 selection process was carried out on the 4th, 5th and 6th of

April. There were 46 candidates interviewed for what turned out to be 27 posts. I had concerns that this 4th year we have undertaken National Selection, there was going to be problems in moving the administrative side from Birmingham (West Midlands Deanery) where we have been well served in the first 3 years of National Selection, to the Wessex Deanery. However, these fears were unfounded. It was very well organised from all of the paperwork onwards in January through to completion and beyond. Of the 19 unsuccessful candidates I have given formal feedback in writing to just over half of them to date.

In addition I have been involved in the Ethicon fellowships which were announced at the Society meeting, and these should be interviewed in late June. This is an exciting opportunity for Senior Trainees in

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Consultancy. One area of weakness has been the establishment of a database of overseas Doctors who may wish to train here for short periods. Although I have been able to facilitate this locally, my plan would be that centres could submit training opportunities they may have for short term training periods of 1-2 years, similar to the previous FTTA posts and try to match these with people who write in from abroad enquiring about a period of training in the UK. Any further suggestions or notification of potential posts would be welcomed.



SCTS Cardiothoracic Forum Annual Meeting 2011

Tara Bartley
Nurse Representative

This year's Annual meeting was held at ExCEL, overlooking the river Thames. With the theme '21st Century Care' the Cardiothoracic Forum was opened by Ms Andrea Spyropoulos, the newly elected President of the RCN. Don't be fooled by the Greek surname, Andrea is very proud of her Liverpuddlian accent and to represent the RCN.

She opened by suggesting that with a substantial proportion of the Cardiothoracic workforce attending the meeting this was not the week to need cardiothoracic surgery! Her speech highlighted the challenge of providing Quality Care in the face of the current NHS efficiency drives and praised the success of the multidisciplinary working which takes place in the Cardiothoracic speciality, examples of which could be seen throughout the programme. She stressed the impact of patient lifestyle choices and health inequalities against the challenges the health professions are facing. Highlighting data from the 'Frontline first' campaign she gave specific examples of planned cuts in the workforce over the next two years and the impact of this upon staffing levels and moral. Her message was about putting patients first and in a climate that demands more for less the need for expertise and skill was paramount.

Andrea's opening remarks were followed by Sir Bruce Keogh who developed the theme with a presentation about the implications of change in the current NHS changes. He shared the blunt realities of delivering quality care in the face of fiscal demise and the true reality of the savings that had to be made in the coming years.

Thoracic Session

During our Thoracic session the plenary speaker was Mr Richard Steyn who talked about Trauma in the pre hospital setting. In an era when there is centralisation of Trauma centres with an increasing demand upon the Cardiothoracic team, Mr Steyn shared case histories of how patients treated at the scene had favourable outcomes in what could have been tragic circumstances.

We have all had to accommodate the introduction of the WHO Check list so it was topical for Mr Stephen Clark to deliver a plenary presentation on the WHO Checklist - Surgical safety checklists; it is worth the effort! While the logic of this process is easy to understand many of us are struggling to embed it within the theatre routine. The conclusions from both the presentation and the audience would suggest its adoption is driven by leadership and most successfully completed where it has been surgeon lead.

Mr. G Bolger, formerly of the DOH spoke on his extensive involvement on Quality Indicators and the way we can measure the care we delivery. Clearly, the ethos of empowering patients with choice has focused our delivery of care on quality. The NHS is now strives to recognise how we give quality care, how we demonstrate this to the public, thus how we measure it and then to satisfy the financial constraints how efficient the service is.

Dr Stephen Green from the National Cardiac Benchmarking Collaborative shared the work they and the trusts involved are undertaking around the country. The remarkable set of data is a major resource that can be used to inform the speciality on excellent service delivery. The extensive work was clearly appreciated by delegates some of who were unaware of the organisations work.

The session given over to workforce issues and the development of Advanced roles was led by Jenny Aston, President of the Advanced Nurse Practitioner Forum. Jenny updated us on the progress of the Standardisation and Regulation of Advanced Practice by the NMC. Disappointingly it would seem they are no further forward in resolving the issue of registration, despite the logistical barriers surely it is time to formally recognise the expertise these roles bring to the profession and patients.

Eighteen abstracts were selected from the thirty-three submitted for the Forum. Congratulations to all presenters whose work went towards creating an excellent two days. A special mention goes to the winners of the £200 Best Paper award as chosen by the audience, which this year was shared between;

Reflection on the Implementation of a Nurse Practitioner Training Programme in a Large Cardiothoracic Surgical Unit

Sandra Laidler¹; F. Thompson²; L. Clarke¹; R. MacFarlane¹; S. Naden¹; G. Newberry¹; S.A. Stamenkovic¹

1 Newcastle-upon-Tyne Hospitals NHS Foundation Trust, United Kingdom;

2 Newcastle-upon-Tyne Hospitals NHS Foundation Trust, United Kingdom

and Minimising Patient Morbidity – The Next Challenge for Cardiothoracic Surgery.

C. Tennyson; D.J. McCormack; S. Ibrahim; P. Lohrmann; A.R. Shipolini The London Chest Hospital, United Kingdom



Sir Bruce Keogh shared the blunt realities of delivering quality care in the face of fiscal demise and the true reality of the savings that have to be made in the coming years

SCTS Forum continued

The £25 Wisepress token awarded to the Best poster was selected by members of the abstract selection committee and was goes to;

Developing a Multidisciplinary Complex Pre and Post Operative Intervention to Reduce Complications and Enhance Recovery after Lung Resection Surgery.

M.Z. Abdelaziz; A. Bradley; P. Agostini; K. Nagarajan; E. Bishay; M.S. Kalkat; R.S. Steyn; P.B. Rajesh; B. Naidu.

Birmingham Heartland Hospital, Heart of England NHS Foundation Trust, United Kingdom

Forum delegate numbers were slightly less than last year which is a sad reflection of the difficulties that nurses and the allied health professional have in procuring time away from work and the financial outlay for professional development. Having recently attended the American Association Critical Care nurses to deliver the CALS course, I was astounded to know that 7000 delegates had registered with the support of their institutions to ensure maintenance of their registered accreditation. Clearly, in the USA there is recognition of the value of professional development and its impact on the delivery of care beyond the individual.

The social scene at the meeting added to the value for delegates. Our thanks go to Joel Dunning and CALS for sponsoring the Nurses and allied health professionals Caribbean night and to Christina Bannister who attended on my behalf. The Annual dinner was held on the magnificent Silver Sturgeon where the chef and team produced the finest meal we have had the pleasure to sample during our many meetings.

Plans are already underway for next years' meeting in Manchester and we will call for Abstracts to be submitted between October and December, so I would encourage you share any projects or work in progress.

Other news from the Speciality;

Deputy Nursing Representative;

I have invited Christina Bannister, Deputy Nursing Representative to introduce herself. Her piece is attached and I am delighted that she has joined me in my final year as the Nursing Representative.

Fellowship of the RCN;

At the recent RCN Congress I was delighted to be awarded the prestigious RCN Fellowship. I would like to express my gratitude for the nomination and those that provided the references. In addition I would like to thank former and current members of the SCTS Executive for providing me with the opportunity and support to undertake my role without which the award would not have been possible.

RCN Research scholarships for nurses and midwives;

This years RCN Congress announced a number of Foundation Bursaries awarded to nurses for professional development. For anyone interested in viewing the winners or applying in the future details can be found at;

www.rcnfoundation.org.uk/bursary_scheme/bursary_winners_2011

The SCTS Cardiothoracic Advanced Course;

This year's course will be held on December 4th & 5th at Heartlands hospital and places will be advertised shortly. We are very grateful to SORIN and Kevin Austin from Wet Labs for their continued sponsorship and support. If you are interested at this time please contact me directly at tara.bartley@ntlworld.com

Update on current issues;

During this year's RCN Congress in Liverpool the current Government published its response to the consultation 'Front Line Care', the report on the future of Nursing and Midwifery in England. Since its publication in March 2010, the Principles of Nursing Practice have been launched. The CNO Bulletin April 2011 states;

'The eight core principles set the direction for nursing and midwifery, in the context of Equity and Excellence: Liberating the NHS, and form the basis of the DH's response to the Commission's recommendations. The principles set out clearly that dignity, responsibility, patient involvement and safety awareness should form the solid foundation for good nursing practice. The response to the 20 recommendations made by the Commission include support for the pledge to deliver high quality care, addressing the contribution of nurses and midwives and their freedom to manage, commission and run their own services..'

Clearly the recent publicity about input from the all sectors of the health professions to the proposed NHS changes, not least nursing should feature to a greater degree than the current process is supported by the RCN.

There is now a listening exercise scheduled to take place involving patient representatives, doctors, nurses and other health professionals to listen and report back to the Government on the Modernisation of the NHS. An exercise that, in the words of Andrew Lansley will be the chance to 'pause, listen, reflect and improve'.

With this in mind it is important to remember that the National Quality Board, who has recently published the first of its two reports restates that as professionals we have a duty to deliver quality care and highlight sub-standard care.

To finish I would like to highlight that Nurses throughout the country took part in events for International Nurses Day on 12 May 2011 and Maura Buchanan, previous President of the RCN attended the ceremony held at Westminster Abbey to celebrate all that is excellent about nursing.

If any of your colleagues would like to add their names to the SCTS Allied Health Professionals database so they can receive the emails that are sent out then please forward there name, address and title to me at tara.bartley@ntlworld.com or direct to Tilly Mitchell at tilly@scts.org

Tara Bartley

Nurse Representative

Deputy Nursing Representative's Report

Christina Bannister
Deputy Nurse Representative

I would like to introduce myself in my new role as Deputy Nursing Representative for the SCTS. It is a great honour to join Tara in promoting the work nurses and allied health professionals do within the realm of cardiothoracic surgery.

Currently I work at Southampton General Hospital as a Nurse Case Manager in Cardiac Surgery, a role I set up at Southampton which encompasses theatre co-ordination, list planning for a specified caseload and one-stop pre-assessment clinics for all cardiac surgical patients. I work alongside a new team of 5 Nurse Case Managers and 4 Advanced Nurse Practitioners in cardiac surgery, and together we ensure all patients coming for cardiac surgery at Southampton have as smooth a patient journey as possible, reduced length of stay and positive patient experience. Within our team we have a Thoracic Surgery Nurse Case Manager and are looking to expand that role also.

At Southampton I work with six cardiac surgeons, who have a love of homemade cake, peanuts, Haribo and good coffee, all which is available in our office which we share with the cardiothoracic SpR's, which as you can imagine has its ups and downs. When I'm not at work I'm normally chasing round after my 2 children who are nearly 7 and 3, doing the usual soccer mom role of taxiing them to and from school, nursery and any other activity they can lay their hands on. On Sundays in the summer you can find us all on Granddad's yacht fighting the rest of the south coast of England for a small stretch of water. As I am originally from Manchester water is something that falls from the sky, so sailing has been a new challenge.

I have been working within the area of Cardiac Surgery and Cardiology for the past 17 years, after completing my nurse training at the University Of Wales College Of Medicine in Cardiff. Post qualification, I specialised in Cardiac Nursing and have worked at both St George's Hospital and St Thomas' Hospital in London. I have worked on Cardiac Surgery and Cardiology wards,

and have cared for patients' both pre and post cardiac transplantation. During my career I have completed an ENB Cardiac Nursing Course and ENB General Principles of Transplantation Course; I have also obtained an MSc in Cardiology at the University of Brighton.

During my current role I have been a member of both the Pan-Dorset Cardiac Surgery & Inter-Hospitals Sub-Group for Dorset Cardiac and Stroke Network and the South Central Cardiovascular Network

Currently I work as a Nurse Case Manager in Cardiac Surgery, a role I set up at Southampton which encompasses theatre co-ordination, list planning for a specified caseload and one-stop pre-assessment clinics for all cardiac surgical patients.

Cardiac Surgery Project Group. I have developed outreach one-stop pre-assessment clinics at the Royal Bournemouth Hospital and Frimley Park Hospital, and at Southampton I am the clinical co-ordinator for the joint Cardiac Multi-disciplinary Team Meeting.

I hope that throughout my term as Deputy Nursing Representative for the SCTS I will be able to develop the role by continuing the good work already started by previous Nursing Representatives in creating a collaborative approach to cardiothoracic surgery, through promoting multi-disciplinary working. I would like to continue to increase the profile of nurses and allied health professionals within the Society and beyond. As a Nurse Case Manager I work alongside Advanced Nurse

Practitioners and Surgical Care Practitioners and would like to develop both roles within the changing face of nursing. The reduction in junior doctors working hours with the European working time directive has created an enormous opportunity to develop the scope of nursing practice and with my experience and enthusiasm I would like to work with nurses and allied health professionals across the country to support their work and continue to develop guidelines and structure for emerging nursing roles.

Through my experience in working within the South Central Cardiac Network I would like to promote nursing networks across the country, not just with experienced and specialist nurses but within the junior staff working on cardiothoracic wards and outpatient departments. Especially in today's difficult and challenging nursing environment I feel that all nurses in cardiothoracic surgery should link together to support each other within everyday nursing practice. We all face the same daily challenges and more time on the wards is spent away from actual hands on caring for the patients undergoing cardiothoracic surgery. I believe that through better networking across the country we, as nurses and allied health professionals, can increase the time and quality of care we provide for our patients by sharing excellent practice and not trying to re-invent the wheel.

Finally I would like to build on the links already forged throughout the nursing and surgical communities to enhance the educational opportunities available for cardiothoracic nurses and allied health professionals, throughout the year, and especially at the annual joint SCTS and ACTA conference.

Christina Bannister

Deputy Nursing Representative

SCTS

Patient Representative

David H Geldard, MBE

It is interesting to note that the involvement of patient representation into the proceedings of the Society does not inhibit discussion and decision making, but rather it seems to enhance it. A good example was at the British Oncology Thoracic Group's Conference in Dublin in January, where a lunch-time breakaway meeting on Addressing Risk Averse Behaviour, attracted a standing-room only group of participants who wanted to tackle the disparities in treating acutely ill patients across surgical centres.

The debate was open and honest, and there was genuine recognition that some patients who were otherwise doomed, were being denied surgery. It was also recognised that the involvement of the patients in the discussions around their prospects was also necessary.

Similarly, at the Society's Annual meeting in London in March, SCTS is deserving praise for arranging its third Patients' Forum, and it is likely that this is the only Forum for a cadre of patient representatives at any other medical or surgical conference. It is a precedent that others are bound to emulate. This year presentations of special interest to patient representatives were received on Surgical Site Infection Surveillance, from St James's Hospital, Ireland; In-house Urgent Patient's Experience Waiting for Cardiac Surgery, from the Morrision Hospital; Same day admission for Cardiac Surgery?, from Leeds; Thoracic Surgery Patient Experience Day, from Leicester; and also from Leeds, Can Patients be Safely Discharged Home on the 4th Postoperative Day? An interactive session with Sir Bruce Keogh and our own Ms Tara Bartley, on "Improving the Experience and the Outcomes for Patients and their Carer", was well received and provoked lively discussion. On more familiar ground, Dr Jane Flint, National Clinical Adviser for Cardiac Rehabilitation gave the Keynote Address on The Current and Future Status of Cardiac Rehabilitation and the Role of the New Commissioning Guide, the session was chaired by Graham Venn and Professor Marjan Jahangiri, who is one of our strongest advocates for CR. All attendees received the recently published National Audit for Cardiac Rehabilitation

Annual Statistical Report 2010. Our delegates came principally through their involvement with their Cardiac Networks, but also from local self help groups and a small group from the thoracic side. We had no representatives from Scotland, Ireland or Wales, and none from Northumberland or the East side of England right down to the South Coast. However we had strong teams from the London area, Merseyside, Greater Manchester and Cheshire, and the Black Country. The Society covers the Meeting side of the patient costs but delegates are expected to arrange their travel and accommodation costs themselves, and several patients were supported in this respect by their own hospital's Cardiac Surgery Benevolent Funds. As these Funds are invariably donated by grateful former patients, this seems to be an eminently sensible and cooperative development.

SCTS deserves praise for arranging its third Patients' Forum, and it is likely that this is the only Forum for a cadre of patient representatives at any other medical or surgical conference.

The majority of cardiac patient representatives come to their new found role through their own involvement in Cardiac Rehabilitation, and they are as keen as mustard to promote its value. The 2010 Statistical Report mentioned above, is only of cheer to surgery patient representatives, as the improvement in take-up of CR was only 3% in 2008-2009 to 41% of all patients from the target groups of heart attack, bypass surgery and angioplasty. As there was no improvement in the numbers of angioplasty and heart failure patients taking up CR, this marginal improvement derives from the continuing improvement in the numbers of bypass patients participating in CR that has risen again to 76%. This is good news, but not

great news. Please remember when you are discharging your patients home, look them in the eye, and tell them straight, "your chances of survival are greatly improved if you join your local CR scheme. So, please, make sure you enrol!" It would be a good idea if each surgical centre could check out the arrangements for your in-hospital first phase of CR, and what formal arrangements are made for referring patients to their local schemes on discharge. Please keep up this good work.

This summer, the National Clinical Director for Heart Disease, Professor Roger Boyle is retiring. We first met at a Modernisation Agency (Heart) conference in 2001, and then I was asked to become a Trustee on the pilot project "Patient Choice in Cardiac Surgery" in 2002, and later on the Cardiac Task Force, and then the National Programme Board. Roger Boyle has been a great support to cardiac surgery and to cardiac surgeons and their clinical colleagues over these years, the resources to move forward in terms of accommodation, staffing, and facilities of all description owe much to his efforts. Professor Boyle has always been a keen advocate of the role of patient involvement in clinical practice in its widest terms, and he has always seen the patient as the focus of all we do. Members of the SCTS and their patients have benefitted enormously from his efforts.

It was pleasing to be asked to contribute a Foreword to the Society's publication "Maintaining patients' trust: modern medical professionalism 2011". This document is a demonstration of openness and confidence that will inspire your patients, their carers, and the public at large. It was an opportunity for me, on behalf of all of your patients, to express a warm message of thanks and appreciation to our surgeons and their teams for the lives that we now lead.

Warmest Regards,

David H Geldard MBE,

Patient Representative and Executive Board Member, SCTS, National Patient Representative for People with Heart Disease.

Quo vadis cardiothoracic anaesthesia?

Peter Alston,
Edinburgh

In 2010, I was invited to write an article for the Association of Anaesthetists of Great Britain and Ireland (AAGBI) Group of Anaesthetists in Training on how to develop one's CV for a career in cardiothoracic anaesthesia. Writing the article gave me pause for thought. Here I was with single digit years between now and my retirement, so I could be pretty confident that it will be possible to continue working in cardiothoracic anaesthesia until then.

However, for someone entering the sub-speciality with maybe 30 odd years before retirement, is there actually a future for cardiothoracic anaesthesia and, if so, what might it look like and, moreover, should it be recommended to trainee anaesthetists as a lifetime career? When I was invited to write an article for the Bulletin, I thought that it might be valuable to develop this train of thought, given that cardiothoracic surgeons may share some of the same concerns for the future, or at the very least, may wish some insight into the motivations of their anaesthetic colleagues who choose to stand on the cerebral side of the blood-brain barrier. Therefore, the aim of this article is to attempt to divine the future of cardiothoracic surgery and anaesthesia, at least in the UK.

Over the last two decades, there has been a burgeoning of cardiac surgery in the UK and this has generated jobs for surgeons and anaesthetists. When I was appointed as a consultant in the early 1990s, it was as one of five anaesthetists undertaking cardiothoracic anaesthesia in the Royal Infirmary of Edinburgh. Although not all are full-time in cardiothoracic anaesthesia, there are now thirteen consultants on the rota. However, surgical activity peaked last year and our unit is contracted to undertake 10% fewer patients this year. Given this downward trend in surgical activity, combined with the worst recession in living memory, the chances that posts arising from retirements will be re-appointed might seem slim and, potentially, cardiothoracic anaesthetists may even be seconded to work elsewhere in the hospital.

Reduction in trainee service commitment

However, because of other current pressures on the system, the prospects for future consultant appointments in cardiothoracic anaesthesia may not be as gloomy as might first appear. The European Working Directive (EWD), combined with the decrease in anaesthetic training posts, has made a big impact on the work of consultant cardiothoracic anaesthetists. Anaesthetic trainees who were once present at every cardiothoracic surgery list are now often absent, as they are on rest periods having done a night-shift or been working over the weekend. Therefore, consultant anaesthetists are now usually working single-handed and this has a major impact on turnover of cases, never mind being not being able to go out for coffee, lunch or the rest room. Furthermore, at least in our unit, trainees are not available for critical care work such as intra- and inter-hospital patient transfers.

is there actually a future for cardiothoracic anaesthesia and, if so, what might it look like and, moreover, should it be recommended to trainee anaesthetists as a lifetime career?

New ways of working

We are trialling a possible solution to this problem by scheduling a consultant on the rota as the, euphemistically named, logistic consultant (also known as tea-boy) to do all the critical care scut work, let single-handed consultant out for coffee, lunch or rest room breaks and to help with the turnover of cases. In addition, dedicated sessions for patients requiring general anaesthesia for interventional cardiology and electrophysiology have been created. These innovations have

ensured that optimum patient care has been preserved, our consultant group has maintained its overall working hours and there is no immediate threat to our numbers. However, it remains to be seen whether or not management will support this re-organisation in the future.

This may provide a potential template for surgeons, although it is hard to envision how consultant cardiothoracic surgeons could effectively cover for colleagues during surgery. Nevertheless, in Sweden some consultant cardiothoracic surgeons actually work in pairs to overcome the lack of trainees to assist during surgery, so maybe a similar system will become routine practice in the UK in the future.

As for the prospects for thoracic surgery and anaesthesia, there appears to be no reduction in patients presenting for thoracic surgery. If anything, we are tackling more sicker and older patients than ever before and there is a steady increase in the number of patients with operable secondary lung tumours. It would, therefore, seem unlikely that thoracic surgery will decrease in the foreseeable future and the need for thoracic surgeons and anaesthetists will continue, or even increase.

Outside the world of cardiothoracic anaesthesia, I have recently proved that I can still safely provide anaesthesia for laparoscopic cholecystectomies, hip pinning, varicose veins, etc, although, to me, it seemed very dull by comparison. In addition, most cardiothoracic anaesthetists have the knowledge and skills to move into general intensive care medicine. For the, rightly, highly specialised cardiothoracic surgeons, it is hard to imagine them walking down the corridor to work in a general, orthopaedic or vascular theatre without some major investment in training in the respective speciality. For anaesthetists, the knowledge that, should the numbers of patients undergoing cardiothoracic surgery fade away, one could always work in other areas of the hospital is a big safety net for trainees entering the sub-speciality of cardiothoracic anaesthesia, and, sadly, one that cardiothoracic surgeons do not share.

Quo vadis cardiothoracic anaesthesia? continued

Echocardiography

In the past, to be successful at a consultant cardiothoracic anaesthetist appointment committee, evidence of research in the form of published papers, or at the very least scientific presentations at relevant meetings, would have been essential criteria. The combination of “run-through” training and the paucity of research now undertaken in cardiothoracic anaesthesia means that published research on trainee CVs are now only desirable. Echocardiography has now replaced research as an essential on an applicant’s CV. Currently, one would be hard pushed to appoint a trainee to a consultant cardiothoracic anaesthetist post without evidence of experience in trans-oesophageal echocardiography (TOE).

TOE is now such an essential tool for many cardiac operations, such as mitral valve

repair and for diagnosing failure to wean from cardiopulmonary bypass (CPB), that future consultant cardiothoracic anaesthetists must be able to use TOE and interpret the images they generate. This will require formal training and then accreditation such as offered by the British Society of Echocardiography or by the European or US equivalents. The research aspect of cardiothoracic anaesthesia was one of the reasons that I was attracted to the sub-speciality and I mourn its diminishment. However, I can only imagine that surgeons recognise the immediate benefits to patient care of having an anaesthetist who is skilled in TOE at the end of their table. In addition, I think there needs to be, and will be, greater development of echocardiography in postoperative care, as it is such a powerful diagnostic tool for complications following cardiac surgery. Furthermore, if only in the area of postoperative care, I

think that cardiac surgeons will also need to up their game and learn the practical aspects of basic trans-thoracic echocardiography.

Intensive care medicine

Intensive care medicine (ICM) is an elephant in the room for both cardiothoracic anaesthetists and surgeons. Postoperative critical care is essential for cardiothoracic surgery and, although different models exist across the UK, historically, both anaesthetists and surgeons have been integrally involved its delivery. When I trained in cardiothoracic anaesthesia, the cardiothoracic surgery trainees spent many, many hours managing patients after surgery and experientially, gained a good knowledge of ICM. In recent years, the number of surgical trainees has been decimated and they have been replaced by staff grade and associate specialist (SAS) doctors. The

Challenge yourself and Join Roger Davies climbing Mount Kilimanjaro to raise funds for The British Heart Foundation’s 50th anniversary

“My name is Roger Davies. Following a heart attack in 2007 I was fitted with a Medtronic Endeavour Stent. The operation was carried out by Dr Pumphrey at St Anthony’s Hospital in London. Following my recovery, I wanted to make sure I continued to live life to the full and embarked on a 350 mile race to the North Pole.

In Jan 2011 I took on my next challenge, this time to climb Mt Kilimanjaro. The experience was incredible and taught me that despite my heart surgery I can be just as active as anyone else. I now want to share this amazing trip and ask you to join me in climbing Mt Kilimanjaro again, to raise funds to mark the British Heart Foundation’s 50th anniversary.

The British Heart Foundation (BHF) works tirelessly to ensure that people don’t die prematurely from heart disease. They support patients, carers and families affected by heart disease and I’m a passionate supporter of their life-saving mission. This trip is a wonderful way to challenge yourself whilst raising funds for the BHF.”

knowledge of ICM held by these SAS doctors is highly variable. Whilst some are excellent, this is sadly not always the case and, as a result, there are times when the standard of patient presentations at ward rounds is less than optimum and there are some nights on call when I sleep less soundly. However, without these SAS doctors many ICUs and HDUs would not be medically staffed out-of-hours.

So is there an alternative to staffing the post-operative critical care areas with SASs? Some units have managed to get their cardiothoracic critical care units staffed with trainee anaesthetists. Personally, I do not see this as a good and sustainable model. To do this would require a large increase in the number of anaesthetic trainees and this is not pragmatic as there is currently an overproduction of anaesthetists with their Certificates of Completion of Training (CCT) and many have no prospect of obtaining a

consultant post in the near future. I work with many excellent nurses who have a superb knowledge and experience of cardiothoracic critical care and I would rather see an enhanced nurse-based model of critical care for out-of-hours.

Whilst I believe nurses should have an enhanced role in the postoperative care of patients undergoing cardiothoracic surgery, I have no doubt that it should be medically led. However, should it be the anaesthetists or surgeons that provide that lead? As much as my surgical colleagues, at least the older ones, might have knowledge and experience of ICM for cardiothoracic surgery, unlike anaesthetists, they have never been formally trained in ICM. Whilst I am firmly of the opinion that cardiothoracic critical care should be anaesthetically led, ICM is problematic for future cardiothoracic anaesthetists as well. ICM has become a speciality in its own right and obtaining

duel qualification and sufficient clinical experience in both cardiothoracic anaesthesia and ICM will be arduous and difficult to achieve.

However, I would not wish future cardiothoracic critical care units to be run by intensivists who have no experience in cardiothoracic anaesthesia, as understanding what happens during surgery is fundamental to managing postoperative care. For this very same reason, the input of surgeons into postoperative critical care is essential for optimal patient recovery. Over recent years, the Association of Cardiothoracic Anaesthetists (ACTA) has increasingly recognised the importance and uniqueness of critical care for patients undergoing cardiothoracic surgery and has set-up a Cardiothoracic Intensivists Group. In addition, it has, and will, run meetings

continued overleaf

Who can participate?

The trip, taking place in February 2012, is open to anyone with or connected to someone with a heart condition:

- **Patients** who have been treated and recovered from a heart condition
- **Friends or relatives** of someone who has a heart condition
- **Heart specialists** such as cardiologists, electro physiologists or cardiac nurses

How will the trip be funded and how much sponsorship must I raise?

Participants will need to fund the trip themselves costing £2,000 and raise a minimum sponsorship total of £500. The aim is to raise £50,000 to celebrate the charity's 50th anniversary, so the more you're able to raise the better!

Contact me

If you, your friends, family or colleagues would like more information about the trip, call me, Roger Davies on 07854 669668 or email me on roger@fish4flies.com





ESTS Meeting in Birmingham 2013

S. Rathinam



We are pleased to announce that we have been successful in our bid to host the 21st European Conference on General Thoracic Surgery in Birmingham in 2013.

The European Society of Thoracic Surgeons is an organisation growing in strength every year and is the largest organisation representing general thoracic surgeons in the world.

The annual meeting is held every year with London 2000, the only conference held in the UK.

The Midlands surgeons presented our bid to host the event in the UK. After careful consideration of venue, access, facilities and costing we decided to host the event in Birmingham with the International Convention Centre and the University of Birmingham as the venue choices. Our bid was supported by the SCTS, the National Lung cancer lead and Cancer Czar. We presented our case and costing to the ESTS in September 2010.

We were short listed along with Istanbul as candidate cities. The ESTS team performed the site visit on the 14th of January and inspected the conference venues and social event sites (Warwick castle and Town hall, Birmingham). Mr David Waller (LOC Chair) was invited to the ESTS council to present our case in Feb 2011. The Council to our delight accepted our bid and were happy to host the meeting in the ICC Birmingham.

Dates: 25-29 May 2013

Congress Venue: ICC Birmingham

English Evening: Warwick Castle

Conference Gala Dinner: Town hall, Birmingham.

We welcome your ideas and contributions to make this event a great success for the UK thoracic fraternity, the SCTS and the ESTS.

We look forward to seeing you all in Birmingham!



Local Organising Committee

Chair : David A Waller,
Glenfield Hospital, Leicester
Vice Chair : Apostolos Nakas,
Glenfield Hospital, Leicester
Secretary : Sridhar Rathinam,
Glenfield Hospital, Leicester
Treasurer : Pala B Rajesh,
Birmingham Heartlands Hospital
Events Secretary : Antonio E Martin-Ucar,
Nottingham City Hospital



Quo vadis cardiothoracic anaesthesia? continued

focusing on cardiothoracic critical care to which all surgeons are most welcome to attend. Hopefully, anaesthetists and surgeons will also have the opportunity to explore ICM next spring at the first Joint Meeting of ACTA and the SCTS in Manchester.

Paediatric cardiac anaesthesia

The delivery of paediatric cardiac surgery is about to undergo major change in England as a result of the Safe and Sustainable Review of Children's Congenital Heart Services. In Scotland, we underwent this process over a decade ago and Edinburgh lost out to Glasgow, which became, sensibly, the single national centre for paediatric cardiac surgery. The proposals of the Safe and Sustainable Review are out for public consultation but it seems clear that the number of centres undertaking paediatric cardiac surgery will shrink from 11 to seven or even six. Clearly, this is going to have a major impact on the lives of surgeons and anaesthetists working in the centres that close. If they wish to continue working in paediatric cardiac surgery or anaesthesia, they will have to move to a centre that will remain open. This may be extremely hard to do for those with family ties and a developed network of friends. Some may choose not to move for these reasons and, as discussed earlier, this may be an easier option for anaesthetists than for surgeons because of their more readily transferable skills. Nor will it be easy for those that work in the six or seven centres that remain. These will require major changes in infrastructure and organisation and amalgamation of personnel is unlikely to come together completely smoothly.

Training

The final point I wish to address is the training of future cardiothoracic anaesthetists. In August 2010, the Royal College of Anaesthetists (RCA) published the new Curriculum for CCT in Anaesthetics. Cardiothoracic anaesthesia is one of the seven essential units for intermediate level training in Speciality Training (ST) years 3-4 and one of the five for higher training in ST years 5-7. However, in each case, the minimum requirement is for four weeks and is defined as 20 sessions. Potentially, this is far less exposure to cardiothoracic

anaesthesia than current consultants in cardiothoracic anaesthesia will have experienced in the equivalent periods of their training. However, in compensation the Curriculum has cardiothoracic anaesthesia as one of the eight advanced units of training in ST years 5-7 and a trainee can spend a maximum of one year in a single unit or six months in each of two units. One year in cardiothoracic anaesthesia might barely be enough training for a consultant who does only anaesthesia. In our unit, the current combined impact of the EWD and reduction of trainee numbers means trainees are infrequently and erratically present on elective lists and as a result have difficulty developing the skills and knowledge required to become a consultant cardiothoracic anaesthetist, never mind being proficient in TOE or having advanced training in ICM. To me this points to the concept of a post-CCT fellowship or a junior consultant post to gain sufficient clinical exposure to be a safe cardiothoracic anaesthetist. For the few cardiothoracic trainees that remain, I can see that they have the same problem of getting sufficient continuity of exposure to elective clinical surgery.

If the training of cardiothoracic anaesthetists is problematic, then it is doubly so for paediatric cardiac anaesthetists. Indeed, this exact point was highlighted during the Safe and Sustainable Review. Traditionally, paediatric cardiac anaesthetists came from two different backgrounds depending on the type of centre in which they were trained. One group came from the major paediatric hospitals that undertook cardiac surgery and so came from the background of paediatric anaesthesia. The other group came from cardiac centres that undertook paediatric as well as adult cardiac surgery and so came from the background of cardiothoracic anaesthesia. Clearly, both routes have their merits and demerits but there has not been a clear definition of what curriculum is required to train a paediatric cardiac anaesthetist. The Association of Cardio-Thoracic Anaesthetists (ACTA) has made recommendations to the Royal College of Anaesthetists (RCA) who will decide on the training requirements. However, it will clearly take post-CCT training, if not

mentorship of newly appointed consultants. As a result of successful paediatric cardiac surgery, there will be an increasing number of grown-ups with congenital heart disease (GUCH) that will require revision of their heart surgery as well as non-cardiac surgery and obstetric anaesthesia. Therefore, it is important that future training produces cardiothoracic anaesthetists that are capable of managing GUCH as well as paediatric surgery. Indeed, this will also be true for surgeons and the increasing number of GUCH patients is also another reason to be optimistic for the futures of both cardiothoracic anaesthetists and surgeons.

Conclusion

In medicine, one can never tell when the next magic bullets will be found. There may be a cure for coronary artery disease, and even for lung malignancies, and then there would be no requirement for cardiothoracic surgeons and cardiothoracic anaesthetists. However, my divinations into the foreseeable future would suggest that there will be enough cardiac and thoracic surgery work to mean that there will be a future for cardiothoracic surgeons and anaesthetists. Notwithstanding that future, we share major challenges that must be addressed, most notably training the future cardiothoracic anaesthetists and surgeons, training anaesthetists and surgeons in echocardiography and how to staff and run cardiothoracic critical care units. Finally, it is fitting to end with a quote from Niels Bohr (1885 – 1962) "Prediction is very difficult, especially if it's about the future".

R Peter Alston,

Consultant Anaesthetist,
Royal Infirmary of Edinburgh.

Advances in TAVI: 'Valve-in-Valve' Implantation for failed Bioprosthetic valves

*Mr. Vinnie (Vinayak) Bapat
Consultant Cardiothoracic Surgeon
Guy's and St. Thomas' Hospital, London*

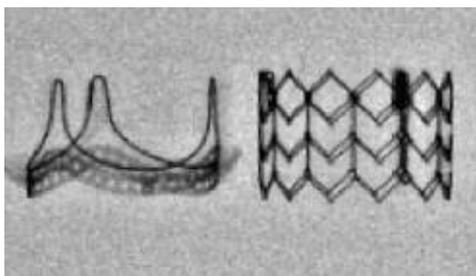
There has been a steady increase in usage of bioprosthetic valves in UK and across the globe. The cut-off age for implantation of a bioprosthetic valve has also been lowered from 70 yrs to 60 yrs in North America. We have seen a similar trend across cardiac centres in UK with increasing number of patients preferring a bioprosthetic valve over a mechanical valve due to issues with anticoagulation. With time, a bioprosthetic valve is expected to degenerate and eventually fail. Thus, patients who are undergoing a bioprosthetic valve implantation today will present in their 80's for a reoperation. Until now, reoperation has been the only possible treatment though it carries a significant risk. The STS risk calculator predicts that an 80-year old man with no comorbidities has an approximate mortality risk of 5%, while his EUROSCORE is 14%. These risks increase dramatically in presence of comorbidities which are not uncommon at this age.

Transcatheter aortic valve implantation (TAVI) has recently been established as a feasible alternative to conventional valve surgery for the management of high-risk elderly patients with aortic stenosis. TAVI might also present an attractive option for patients with failing bioprosthesis as a 'Valve-in-Valve' procedure.

'Valve-in-Valve'

Success of TAVI is dependent on

1. Choosing the correct size of the prosthesis in relation to the native aortic annulus diameter and,
2. Correct positioning across the native aortic annulus.



A - Fluoroscopy image of a 29 Perimount and a 29 Sapien valve

Edwards Sapien valve is currently available in 3 sizes (23, 26 and 29mm). Correct choice is dependent on the aortic annulus diameter. Sizing is generally performed on TOE. Recommended sizes for a Sapien valve are as follows:

| Sapien Valve Size | Annulus size on TOE (mm) |
|-------------------|--------------------------|
| 23 | 18 to 21 |
| 26 | 22 to 24 |
| 29 | 25 to 27 |

Sizing is operator dependent; experience guides choice in cases with borderline annulus diameters. This is important as choosing a smaller device can lead to embolisation or significant paravalvular leak and a bigger valve can lead to annular rupture. Similarly, correct positioning of the device is of paramount importance to avoid coronary obstruction or embolisation in the aorta if it is placed too high or embolisation in the ventricle if it is placed too low. Positioning can be especially tricky in patients with poor calcification as visualisation of the hinge points is difficult.

However, in a stented bioprosthesis, these anxieties are taken away as one knows the internal diameter of the bioprosthesis and the radio-opaque stents provide excellent markers for perfect positioning of the TAVI device.

Sizing:

Prosthetic heart valves are labelled by their external diameter but their internal diameter varies by manufacturer, model and size (Table)



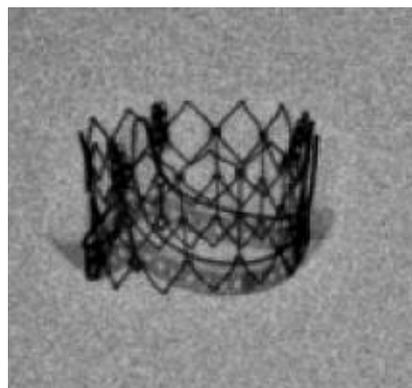
| Size | Type | Stent Internal dia.(mm) |
|------|-----------|-------------------------|
| 21 | Perimount | 20 |
| | Mitraflow | 17.3 |
| | Mosaic | 18.5 |
| 23 | Perimount | 22 |
| | Mitraflow | 19 |
| | Mosaic | 20.5 |

Thus it is of paramount importance to confirm the internal diameter and then choose the appropriate device; eg. a 21mm bioprosthetic valve with an internal diameter of 17.3 mm may not be an ideal case to be treated with a 23mm TAVI device as it will lead to under expansion of the TAVI device and also leave the patient with high residual gradients (Russian doll effect). Future availability of a 20mm device will allow us to treat such patients.

We also recommend confirming the internal diameter with TOE as bulky leaflets and pannus can further narrow the internal diameter. For example, we recently implanted a 23mm valve in a patient with a 25 Mosaic valve with an internal diameter of 23 mm, which on TOE was 21.5 mm due to pannus.

Positioning:

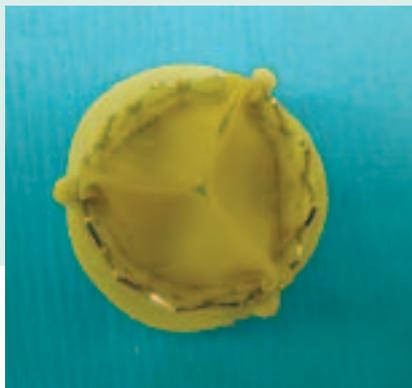
Majority commercially available bioprostheses have radio-opaque markers. It is important to achieve fixation within the annular ring of the bioprosthetic valve as stent posts can be easily displaced by radial force applied during implantation of the device. We recommend at least 10% of the device to be below the annular ring (Figure). Rapid ventricular pacing and slower deployment is the key to achieving a satisfactory position.



B - Fluoroscopy image of 29 Sapien inside a 29 Perimount valve



C - Bench test of 29 Sapien within a 29 Perimount 'side view'



D - Bench test of 29 Sapien within a 29 Perimount 'top view'



E - Valve in valve 'Mitraflow'.

Stentless valves:

This also includes homografts and various stentless valves, which have been implanted in the last decade. Valve-in-valve in a stentless valve is challenging and should be undertaken by an experienced team. The majority present with aortic regurgitation, have minimal calcification and have no radio opaque markers. Thus adequate fixation of the TAVI device relies entirely on over-sizing of the device and positioning needs to be aided by TOE and a distal marker, such as a guidewire in the left main. Coronary obstruction is a

possibility as the suture lines may be very close to the coronary ostia and/or due to over-sized device required in these cases.

Guys and St. Thomas' experience:

We have performed 15 cases of 'Valve-in-valve' with no mortality and satisfactory results in all. Of these, 10 patients had a stented bioprosthesis and 5 patients were stentless valves (2 homografts). One of these patients is a 29 year old with a 29 Perimount valve who has had 4 reoperations from the age of 8 months on

his aortic root. He underwent a 29mm valve-in-valve procedure using a Sapien valve and was discharged home on the 4th day.

Cases have also been performed for degenerated bioprosthesis in mitral, tricuspid and pulmonary positions. With increasing experience we are likely to see a growth in 'Valve-in-valve' usage in our clinical practice.

Mr. Vinnie (Vinayak) Bapat

Consultant Cardiothoracic Surgeon
Guy's and St. Thomas' Hospital, London

Prize Winners

Society Thoracic Medal for best thoracic presentation:

Operative Surgical Training in General Thoracic Surgery: Transitions in Trainee Structures and Training Models

Presenter: Kirsten Morgan Bates

Co-Authors: O.A. Jarral, Z. Sarang, G. Ladas, M. Dusmet, S. Jordan, E. Lim

The Royal Brompton Hospital and Imperial College London

Ronald Edwards Medal for best cardiac clinical presentation:

Intracellular Calcium Handling in Donor Heart: Comparison of DCD and Brainstem Dead Donor Hearts

Presenter: Fouad. J. Taghavi

Co-Authors: A. Ali, C. Woods, S.R. Large, E. Ashley

Stanford University Hospital, USA and Papworth Hospital, United Kingdom

John Parker Medal for best scientific presentation:

Effect of Normothermic Cardiopulmonary Bypass on Renal Injury in Paediatric Cardiac Surgery: a Randomized Controlled Trial

Presenter: Nishith Patel

Co-Authors: S. Bays; A. Pawade A. Parry; S. Suleiman; G.D. Angelini; M. Caputo

Bristol Heart Institute, University of Bristol

Society Cardiothoracic Forum Medal, Joint Winners for best forum presentation:

Reflection on the Implementation of a Nurse Practitioner Training Programme in a Large Cardiothoracic Surgical Unit

Presenter: Sandra Laidler

Co-Authors: F. Thompson; L. Clarke; R. MacFarlane; S. Naden; G. Newberry; S. Stamenkovic; S. Clark

The Freeman Hospital, United Kingdom
and

Minimising Patient Morbidity – The Next Challenge for Cardiothoracic Surgery

Presenter: Charlene Tennyson

Co-Authors: D.J. McCormack; S. Ibrahim; P. Lohrmann; A.R. Shipolini

The London Chest Hospital, United Kingdom

Winner of the **Student Poster Presentation**

Should double lung transplant be performed with or without cardiopulmonary bypass?

Presenter: Myura Nagendran

University of Oxford, Supervised by D Taggart, John Radcliffe Hospital.

Winner of the CT Forum prize:

Developing a Multidisciplinary Complex Pre and Post Operative Intervention to Reduce Complications and Enhance Recovery after Lung Resection Surgery.

M.Z. Abdelaziz; A. Bradley; P. Agostini; K. Nagarajan; E. Bishay; M.S. Kalkat; R.S. Steyn; P.B. Rajesh; B. Naidu

Birmingham Heartland Hospital, Heart of England NHS Foundation Trust, United Kingdom

The CALS Course goes international

It's been a busy year for the CALS (Cardiac Surgery Advanced Life Support) course. Last year saw us help the European Resuscitation Council rewrite the official recommendations for resuscitation of patients after cardiac surgery to the way that we teach it and to conform to the official EACTS guidelines on this subject that we helped publish in 2009.



Admittedly it was not given very high prominence in the ERC guidelines, being on page 1417 of the special circumstances chapter, but nevertheless our course now teaches the official way to resuscitate someone who arrests after cardiac surgery. But following the publication of these guidelines and our live demonstration at the EACTS conference, interest has exploded this year.

We were invited to Geilo in Norway where we sent a team of 4 people to demonstrate the protocol to their national conference. Then only 3 weeks later we sent another 5 people to Hungary to perform their first course too. St. James' in Dublin is now running its own courses and we just sent a single person and a dummy there to help out. This was in addition to

national courses in Wolverhampton and St Georges this year and two overseas invitations at the end of last year to Syria and Iran of all places! Then 3 of us went to the USA to America's National Conference for Critical Care nurses in Chicago while the rest of you were watching the Royal Wedding. This was a real eye opener. This is a conference of 7,000 critical care nurses. We ran 2 one day courses with 32 people booked onto each day. But throughout both days people kept coming along saying they couldn't get booked in as it was full so quickly and could they watch.

Two things really struck us in the USA. Firstly the nurses were outstandingly competent and had the knowledge of post-operative management of a patient equivalent to a competent 3rd or 4th year registrar here. The second thing that stood

The EACTA Lecture Series of Perioperative Echocardiography

Editors:

Duthie D and Swanevelder J

The lecture series are packaged into two DVDs.

One DVD covers the accreditation course. It consists of 18 lectures and an abstract book. The other DVD covers the advanced course. It consists also of 18 lectures, an abstract book and mock exam. Each lecture lasts 20 minutes.

The accreditation lectures are comprehensive in covering all aspects of transoesophageal echocardiography examination. It starts with basic physics and standard views; and end with prosthetic valves and congenital heart disease.

The advanced course dealt with a number of clinical scenarios, offering useful practical tips; and new imaging techniques and technology. I particularly enjoyed the lectures on diastolic dysfunction and

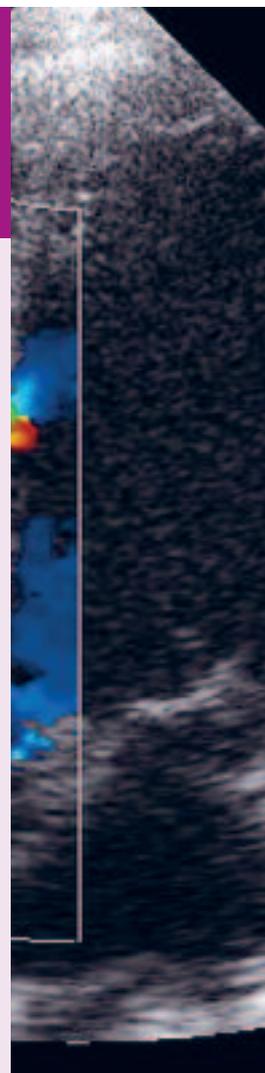
tissue doppler imaging. The talk on emergency echocardiography in ICU is both informative and entertaining. The mock exam will be of interest to any prospective candidate.

The lectures are delivered by a number of speakers. Therefore there are variation in style and some repetition. The DVDs are in Macromedia format. This program does not allow full screen viewing on the computer. As a result, the labels/numbers on some slides were difficult to read.

Overall the DVDs are excellent resource material either as standalone or to complement other textbooks. I can recommend them to both novice and intermediate transoesophageal echocardiography practitioners.

Julian Wang

Edinburgh Royal Infirmary



Joel Dunning



came in, uniformly with the expected outcome. It does seem like a scandal waiting to happen out there. I was in fact surprised that no savvy lawyers have got a hold of this fact and asked the question 'what would have happened to my client's father had the tamponade been relieved in 3 minutes rather than 30 minutes'. But it seems that the expense of resident surgeons for this rare event means that they will never be

able to change their system to resident surgeons, hence the very large interest in our course that trains the people by the bedside to respond fully to the arrest and if necessary reopen the chest.

out was the reason that they were so good. They were mostly very senior nurses who ran their units, but in contrast to the huge American units that we hear about at the conferences, many of them worked in one of the 1,250 units in the USA that were much smaller. Many had only 2 or 3 full time surgeons and no resident surgeons overnight. They managed all the post-operative care with the surgeon on the end of the phone. There were also, in most cases, no resident cardiothoracic anaesthetists. Thus the nurses had to make most of the bigger decisions overnight themselves and were routinely used to starting inotropes, bringing in cardiologists to do echos, and even putting in balloon pumps if they were nurse practitioners.

The horrifying thing was that most of them had a story or two of arrests due to tamponade where they just massaged for half an hour or longer while the surgeon

So all of us involved in CALS are looking to the future wondering how we are going to manage getting to all these training venues. We are in active discussions with the ERC to come under their umbrella as an official ERC course which will remove our current 'back of the envelope' status where we deliver the course as a group of enthusiastic surgeons, anaesthetists and nurses. Instead this will be replaced by official ERC CALS Trainers and will come with all the benefits of

being under this organisation. We hope that this will be a reality by the end of the year or early next year. Thus if you are reading this article and you fancy becoming a trainer then please get in touch. We always need more people to teach. We have now performed 31 courses including 13 in-house courses, having been



invited into units who want to perform better in this emergency situation. We need lots of good people who can spread the word and who hopefully will become the first group of ERC CALS Trainers. If you are more junior and want to come on a course then we do have several courses for you too this year.

To find out more, visit www.csu-als.com or look for us on facebook at www.facebook.com/group.php?gid=115765272129&ref=mf

Joel Dunning
www.ctsnet.org/home/joeldunning



Dear SCTS Member

RE: VATS Lobectomy Training Proctorship at St George's Hospital London

It is with great pleasure that we announce the first Vats Lobectomy Proctorship at St George's Hospital London, the aim of this programme is to provide support and assistance to thoracic surgeons who wish to undertake VATS lobectomy. We are delighted that Mr Ian Hunt and Ms Carol Tan have agreed to facilitate this training.

Briefly the training plan will encompass onsite sessions for surgeons and theatre personel at St George's Hospital and then offsite training when the surgeon returns to begin operations at their own centre.

This training will be supported through the professional education department at Ethicon Endo-Surgery.

For further information please contact Mr Ian Hunt at Ian.Hunt@stgeorges.nhs.uk or for an application please contact myself on any of the details below.

Kind Regards

Ross Campbell
Product Manager - Stapling



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The “Safe and Sustainable” Review of Paediatric Congenital Cardiac Services in England

Leslie Hamilton

Although all the surgeons involved in paediatric cardiac surgery are very aware of the current review, we realised that adult cardiac and thoracic surgeons would not necessarily know what was happening.

Background

In the late 1970s, when the specialty was expanding, there were discussions about the need to limit the number of units to maintain a critical throughput of cases. In the 1980s we had “supra-regional” funding for neonates and infants – to try and limit the number of centres undertaking cardiac surgery. However, no politician had the courage to use this tool to achieve the aim of larger centres. It is sobering to reflect that had they done so, “Bristol” would probably not have happened.

In 2001, in the final “Inquiry” Report, Sir Ian Kennedy’s panel made 198 recommendations, only 7 of which were specific to paediatric cardiac surgery. Three of these related to the need for larger centres / bigger throughput. These were ignored.

In 2003, Jim Monro (then President of SCTS) chaired “Paediatric and Congenital Cardiac Services Review” – the Minister “was not minded” to accept the main recommendation to have larger (and therefore fewer) centres.

In 2006, Roger Boyle convened a meeting of representatives of all the units at the Department of Health. The unanimous conclusion was that something had to be done – maintaining the current number of units was not a viable option.

Meanwhile things were occurring in units around the country which created instability in the surgical service – illness, emigration and retirements. The Executive Committee of SCTS asked the then President (Bruce Keogh) to write to the Minister to highlight the problem. As you know, Bruce was subsequently appointed to the post of NHS Medical Director and his first task (the Minister gave Bruce the letter he had written from SCTS!) was to persuade the NHS Management Executive that change was necessary.

So was born the “Safe and Sustainable” review.

The Review Process

Paediatric cardiac surgery is currently commissioned at regional level - each Strategic Health Authority has a specialist commissioning panel. The chairs of each of these 10 panels became the JCPCT (Joint Committee of Primary Care Trusts) – this is the body with the legal responsibility to make the decision on the future configuration of the service. An advisory “Steering Group” was established, chaired by Patricia Hamilton, past President of the RCPCH and comprising parents and professional representatives: the Presidents of SCTS, BCCA (British Congenital Cardiac Association – the President elect was also included) and PICS (Paediatric Intensive Care Society)

*The number of cases
was more
challenging. Looking
at a number per week
to maintain skills,
three is the magic
number.*

and nominees from ACTA, the Royal College of Nursing, the RCPCH (Royal College of Paediatrics and Child Health). There was no question of individual units being represented. Additionally a surgical BCCA member was co-opted in view of his experience in three nationally commissioned services including transplantation and ECMO.

Although the review was asked to focus on paediatric cardiac surgery, the Steering Group were aware of the need for a consistent approach with the standards for adults with congenital heart disease (ACHD / GUCH) that were published in 2009 by a separate working group, and so an ACHD representative was co-opted.

The Standards

The first task was to set the proposed standards for the service in the future – a “Standards” working group was established with wide representation and chaired by Bill Brawn. The aim was to achieve the highest quality care. See: www.specialisedservices.nhs.uk/document/paediatric-cardiac-surgery-standards The key in future will be that care will be provided by “managed clinical networks” with the surgical centres being responsible for the quality of care within their network.

It will not surprise you that the most challenging standards on which to agree a consensus were the number of surgeons in a unit and the minimum number of paediatric cases. The number of surgeons was relatively easy – to allow for leave, 7 day working for urgent cases, mentoring of new appointees and succession planning, 4 are necessary.

The number of cases was more challenging. Looking at a number per week to maintain skills, three was the magic number. Over a 43 week working year, this equates to 129 – remarkably similar to the 125 recommended by EACTS some years ago. Thus 500 per unit. However this could have meant about 5 units in the country, thus reducing access for many families. In recognition of this a minimum of 400 paediatric cases was set, accepting that in most centres the same surgeons would also be doing some adult congenital surgery. Another influencing factor was to look at the units around the world that we regard as “centres of excellence” – the ones to which we send our trainees. All doing at least 500 and most in fact doing much more. There is also increasing evidence in the literature (an independent literature review was commissioned) in many surgical specialties (including paediatric cardiac surgery) of a positive relationship between volume and outcome. In our field this is especially the case in neonatal cardiac surgery.



Review of Paediatric Congenital Cardiac Services in England *continued*

Accepting that there is no cut-off number for improved outcomes in paediatric cardiac surgery, most authors conclude that volume is a surrogate marker for quality of care. A major advantage of bigger centres is that they would have a similar case mix and this would allow a more robust statistical comparison of outcomes (we do not currently have an accepted method of risk scoring equivalent to EuroSCORE).

Sir Ian Kennedy then led a panel of clinical representatives to visit and assess every unit against these standards - both how they fare now and how they could achieve them in future (NB: surgical outcomes were not part of the assessment). The panel gave each unit a composite score. Not surprisingly some have interpreted this as a league table with this novel, subjective score being an absolute marker of quality.

External Review

Any major change in the NHS comes under scrutiny by a number of bodies – all have been supportive of the process. In particular the National Clinical Advisory Team (NCAT) said: “it is not acceptable to do nothing”. Also: “using a figure of a minimum of 4 surgeons per unit as an absolute minimum does make sense..” They concluded: “NCAT can support the

case for reconfiguration of paediatric cardiac surgery, reducing the number of cardiac surgery centres.”

Possible Configurations

After prolonged deliberation and taking into account a wide range of issues, the JCPCT came out with 4 possible configurations for public consultation— two with six centres and two with seven. All of the centres currently undertaking paediatric cardiac surgery are in at least one of the options. All of the configurations were based on the proposal to have 2 centres in London: at Evelina (St Thomas’) and Great Ormond Street (supporting the independent proposal to merge the current units at GOSH and the Royal Brompton).

Monitoring outcomes

Although we have the best monitoring process in the world for congenital heart services, commissioners have (quite rightly) really pushed the steering group to think about how the current system can be improved. This is not an easy task, but there is agreement on the need to implement real-time alert systems in surgical units and a need to collect, analyse and report on meaningful morbidity data. This would be truly ground-breaking, and easier to achieve with larger units.

Summary

By the time you read this, the public consultation will have ended on 1 July, coinciding with the 10th anniversary of the publication of Sir Ian Kennedy’s report following the Bristol inquiry.

Public events have been held in all parts of the country, both to listen to the views of parents, patients and staff and to explain the process. Clinical members of the Steering Group have fronted these events. The results of the consultation process will be collated by Ipsos Mori and presented to the JCPCT in the autumn. A decision will then be made with implementation planned by 2013.

But then the really difficult work begins! In 2009 Bruce Keogh called upon surgeons and others to set aside their personal interests for the greater good of the children of this country. He suggested that failure to reconfigure children’s heart surgery this time around would be a ‘stain on the soul of the speciality’.

Some countries have already gone through this process. Others know they need to do so and are watching! Further details of the Review can be found at: www.specialisedservices.nhs.uk/safeandsustainable

Leslie Hamilton

A D V A N C E N O T I C E

Joint Meeting

ACTA - SCTS

Manchester Central

18 - 20 April
2012

Save the Date



Association for
Cardiothoracic
Anaesthetists



Society for
Cardiothoracic
Surgery
in Great Britain
and Ireland



SCTS RESPONSE

To Proposed Nice Guidelines

*NICE Stable Angina
Guideline Committee*

SCTS welcomes the opportunity to comment on the proposed NICE Guidelines for stable angina. From the outset SCTS would emphasise that it strongly supports the NICE principles and process. While the guidelines are extensive, covering 456 electronic pages, SCTS will confine its remarks to those sections dealing with recommendations for revascularisation interventions.

The most striking feature of the proposed NICE recommendations are that their recommendations for revascularization are in almost direct opposition to those of the most definitive contemporary guidelines on revascularization from Europe, which examined the same evidence base as NICE. Furthermore, and as detailed in the accompanying document, the European guidelines were recently strongly endorsed in a Heart editorial from the respective Presidents of the British Cardiac Society, the British Cardiovascular Intervention Society, SCTS and the National Director for Heart Disease and Stroke.

On review of the proposed NICE recommendations SCTS have a number of concerns, including omission, misinterpretation and misrepresentation

of crucial data at odds with NICE conclusions. Of greatest concern, however, is the NICE proposal, stated under 'Key Priorities for Implementation' that in effect an individual cardiologist can consider PCI even for any three vessel and left main disease if they, alone, consider the 'anatomy suitable'. This is not only at odds with the best available evidence (while simultaneously undermining the principle of the multidisciplinary team) but SCTS also believes that this is a potentially dangerous recommendation.

SCTS does not support the proposed NICE guidelines in their current format, but would propose a complete re-writing of the revascularization recommendations and preferably in a more objective fashion.

Accordingly SCTS does not support the proposed NICE guidelines in their current format but would propose a complete re-writing of the revascularization recommendations and preferably in a more objective fashion.

In view of our concerns we have copied this letter to Sir Andrew Dillon (Chief Executive), Sir Michael Rawlins (Chair of Non-Executives Directors), Prof Roger Boyle (National Director for Heart Disease and Stroke,) Dame Sally Davies (Chief Medical Officer NHS) and Professor Sir Bruce Keogh (Medical Director NHS).

Kind regards

| | |
|-----------------|-------------|
| DP Taggart | M Jahangiri |
| J Roxburgh | S Kendall |
| G Cooper | S Livesey |
| M Dalrymple-Hay | N Moat |
| C Bannister | S Ohri |
| T Bartley | J Pepper |
| B Bridgewater | R Shah |
| J Duffy | S Westaby |
| B Evans | I Wilson |
| D Geldard | |

New Appointments

| Name | Hospital | Specialty | Starting Date |
|--------------------|--------------------------------------|----------------------|---------------|
| Kandadai Rammohan | Wythenshawe Hospital, Manchester | Thoracic | February 2011 |
| Choo Ng | Papworth Hospital, Cambridge | Adult Cardiothoracic | 2011 |
| Haralabos Parissis | Victoria Hospital, Belfast | Cardiothoracic | May 2011 |
| Narain Moorjani | Papworth Hospital, Cambridge | Adult Cardiothoracic | June 2011 |
| Eveline Internullo | Nottingham City Hospital, Nottingham | Thoracic | July 2011 |

Other Appointments

| | | | |
|------------------|--------------------------------|--|------------------|
| Ram Dhannapuneni | Alderhey Hospital, Liverpool | Locum Consultant Paediatric Cardiac | November 2010 |
| Ajay Moza | Harefield Hospital | Locum Cardiac Transplant | January 2011 |
| Natasha Khan | Birmingham Children's Hospital | February 2011 Paediatric Cardiac | Locum Consultant |



The demise of a thoracic surgical service

At an 'open day' held by the Guy's and St Thomas' thoracic unit a visiting physician asked why the peripheral minor thoracic surgical service at her hospital had ceased. As I think I was the last thoracic surgeon in England to have provided such a service so I thought it appropriate to set out the history of these peripheral lists and explain why they no longer exist.

For decades it had been possible for chest physicians to put their patients on a thoracic surgical list and have minor investigative or therapeutic procedures carried out at their local chest hospital. The patients benefited in that they did not have to travel to a major hospital. Also they had continuity of care as they remained in the same chest physician's bed after their procedure that they were in beforehand. The physicians benefited because they knew immediately what had happened to their patients. The pathologists enjoyed seeing material otherwise the province of a teaching hospital and the anaesthetists benefited because they could practice and teach in an attractive specialist field. So what went wrong? Why cannot the modern NHS offer such a service? Let us look at the history.

Until the discovery of effective antituberculous chemotherapy in the late 1940s TB made up a large component of a thoracic surgeon's workload, lung cancer then being relatively uncommon and there were a large number of TB sanatoria throughout the country. The mainstay of treatment of pulmonary TB then was to 'rest' the lung, usually by collapsing it in one way or another. The simplest was to induce an artificial pneumothorax, the most complex was to perform a five rib thoracoplasty. This was performed under local anaesthesia! Thoracic surgeons would visit these outlying sanatoria and perform a wide range of surgical procedures, including thoracoplasties. Nowadays thoracoplasty, rarely performed, is considered a major procedure and anaesthetists often stipulate that an intensive care bed be available.

As TB declined in incidence so the sanatoria closed or became general hospitals. The peripheral minor thoracic lists with their visiting surgeons continued though much of the work was associated with investigating lung cancer and treating more common chest problems such as empyema or pleural effusion. From the mid 1950s Robert Brain, consultant thoracic surgeon at

Guy's, used to go down to Bevendean Hospital in Brighton once a week and carry out up to twenty operations in a morning, albeit many were rigid bronchoscopies under general anaesthesia. When he retired in 1980 I was appointed as his successor and continued his practice of a Tuesday morning operating list, a lunch time chest conference and an afternoon out-patients. The patients from the Brighton, Worthing and Haywards Heath areas were thus spared from coming up to London for relatively minor procedures. Furthermore they remained under the care of their chest physicians who had looked after them up to the operation and would continue to look after them following surgery, true continuity of care. Bevendean Hospital eventually closed and in 1986 the chest unit moved to Hove General Hospital but this too closed in 1997 and finally the thoracic list ended up at Brighton General Hospital where it ceased in October 2003. For historical reasons the operating list was always referred to as 'the bronchoscopy list' even though thoracotomies were not infrequent and bronchoscopies became the province of the chest physicians. Biopsies using image intensification and of course Video Assisted Thoracic Surgery (VATS) were all embraced as they became available. Oesophageal procedures included balloon dilatation for achalasia and feeding gastrostomies. Major surgical complications were very rare.

Why did this apparently successful system end? As always the causes were multifactorial, though changes in doctors' working practices were probably the most important. For many years there had been a clinical assistant, later associate specialist, who was an excellent doctor, and he appeared to be there all the time, partly because he lived with his family in hospital residential accommodation, now also a thing of the past. Thus when the surgeon went down to do the list he would take him round and show him all the patients. His clinical acumen was astounding and we respected his judgement about suitability for surgery almost unquestioningly. He had been there a long time and had seen a lot. Inevitably and deservedly the chest physicians acquired two SHOs which meant that it was possible that the SHO on duty on the day the surgeon came may not have been the one who admitted the patient the day before.

For most of the history of the thoracic surgical service it was tacitly understood that patients for that list would be given priority of admission over other non urgent patients. This seemed sensible, the surgeon only came once a week and the conditions needed prompt investigation or treatment. However the pressure on beds in Brighton worsened progressively with the result that patients' admissions were frequently cancelled or they may be admitted late in the evening when a bed did finally become available. As a consequence of the further reduction in



Bevendean Hospital, 1963



Fig. 20.—Position for pericardial thoracotomy and the primary bronchus.



junior doctors' hours they would then probably be admitted by a doctor from a completely different discipline.

Furthermore, the admitting SHO could not obtain informed consent from the patients as the doctor obtaining consent has to be fully conversant with the procedure and in particular the risks. This meant that instead of going down to Brighton and

finding fully clerked, consented and informed patients with all their investigations I would have first to find the patients, then take a history, examine them, assess their CT scans etc. and obtain consent. Additionally they could not be given a premed before all this had happened. The pressure on the surgeon, and particularly the anaesthetist was enormous especially bearing in mind that the patients by definition had chest disease and many were frail and some extremely sick.

As already mentioned, this was an 'open access' list, i.e. referring consultants could send in patients unseen by the surgeon who would take these patients on trust. This worked well when the patients were referred by experienced chest physicians but patients were also sent in from other sources. Despite a rule that all patients should be discussed 'consultant to consultant' the system was abused and with the absence of dedicated junior staff there was no gatekeeper. Critical information was often concealed, in particular the fact that a patient had Clostridium Difficile or MRSA. The arrival of such patients on the chest ward placed an intolerable burden on the staff, let alone the clinical risks they engendered. Patients would also arrive without vital information such as their X rays or CT scans. Sometimes the patients were given totally erroneous information by their referring doctor, for example a patient being sent for a VATS pleurodesis for a complex pneumothorax being told that they would be out of hospital the same day! It would have been easy to turn many of these patients away but they had often waited days or weeks in their referring hospital prior to transfer and for

many their future would depend on the outcome of the investigations or procedures we performed.

Given all these problems it is amazing that the service continued for as long as it did and the only reason it was able to do so was because the staff involved had worked together as a team for many years. All were very experienced. I had been a consultant thoracic surgeon for twenty years, and the consultant anaesthetist was exceptional, not only in anaesthetizing some desperately sick patients but in his clinical acumen and preoperative assessment. I had great respect for his opinions, especially on the advisability of anaesthesia and the surgery. The theatre nurses had worked as a team for many years, so as long as the key personnel were present we felt it safe to continue and in fact we had no major mishaps. But it was with relief that I performed my last operating list in Brighton not sadness.

During this period the facilities and expertise at Guy's had increased enormously so that parallel with the justifiable development of a risk averse culture in medicine it became inevitable that the list should cease in Brighton and the patients treated at Guy's. This trend of closing small units and moving patient care to large centres is of course occurring throughout the NHS though it is not universally popular with the public.



Robert Brain, Alan Yates, Donald Ross

Last, the unsung heroes of this story of peripheral thoracic surgical lists are the chest physicians who have looked after the patients before and in particular after surgery. Their expertise and commitment to the care of these patients combined with a willingness to sacrifice their beds has been fundamental. I know that they are saddened to have lost their surgical service but in the end the patients, given the changing circumstances of specialist surgery, while being inconvenienced should benefit from the improved facilities of a major thoracic centre.

The SCTS Serves *who* first?

The patient is at the center of our attention as doctors and surgeons but do we involve them in the design and decision of their patient specific pathway. Web based information reflecting the Safety and Efficacy of our work is empowering and enabling our patients to make choices.

Very soon sites like www.iwantgreatcare.org will enable patients to rate their Experience. They will be able to comment on how you delivered your service - that will include elements like meet and greet and how well you conveyed information. This will challenge our thinking and ask us to re evaluate our role and relationship with the patient. This same applies to the Cardiologist who to date has been perceived as the gate keeper and to the GP who is very likely to be commissioning our services in the future (no firm decisions are made as yet). We need to, as individuals, teams and as a Society, working with the Cardiologist and the GP, help our patient through a transparent and evidence based decision process without the biases and heuristics intrinsic in a one to one consultation. Decision theory and consent guidelines advocate the best way to meet these objectives is to include the patient in a MDT process.

The 2011 Annual General Meeting Society of Cardiothoracic Surgeons of Great Britain and Ireland, held at the Excel Centre in London was a triumph. The Society yet again, demonstrated its ability to lead in many areas and received an unqualified endorsement from the Secretary of State for Health. Our Society is nationally and internationally recognised for our publications and patient involvement. Our leadership has to be applauded. However, there are going to be many challenges ahead as outlined by our ex-President and our MD of the NHS, Professor Sir Bruce Keogh. Many of the presentations at the Society, demonstrated that units and individuals are tackling many of these challenges in creative ways through

various innovative practices.

The National Health Service is now over 60 years old. However, the way we have delivered our practice over that time has not changed and the plant in which we operate is the same. The NHS suffers from "Structuration" - a consultant of 1948 would not feel out of place in a hospital in 2011. We continue to tinker and fix the noun "health" but we have not focused on the operative word "service".

Service is summarized in the 6 E's'

- Efficacy
 - Do the Means work?
- Efficiency
 - Amount of work divided by the resources
- Effectiveness
 - Is it meeting the long term aim?
 - What is our failure rate over time?
- Experience
 - Is the patient delighted?
- Ethical
- Elegant

The surgery we offer is Effective, Ethical and in many cases Elegant but are we Efficient, Effective and do we really monitor patient Experience.

There are two essential pillars of a good service industry. The first is based on comprehensive real time data. Our data is good but does it inform the process and flow and experience of the patient? The second is defined by values. The publication of the Professionalism book this year, again leads the way.

We can and should go further. We need to benchmark ourselves with the service sector in general. We are all customers in our every day life. We understand what is good and bad service. The

customer value equation is easily adapted for health care. It is defined as Quality divided by Cost (figure 1).

Quality is not what we put into the health service, but what the patient gets out of it. It is defined by both short and long term outcomes as well as the quality of the process. Few within our Society are looking at long term outcomes. Yes, we can plot Kaplan Myer curves but do we document what has happened to our patient after discharge? Have we improved their quality of life? The Health Secretary is now focused on re-admissions - are these avoidable or unavoidable or do we accept readmissions as part of patient centric care? We would do well to use the database again at follow-up clinic to determine these factors and ask about experience.

The Pathway

The process factors include the flow (Patient Care Pathway) and Quality of delivery of a service - delivery and timing that does not directly improve the flow of the patient through the system is referred to as non - value added waste. Institutes like Virginia Mason Medical Centre in Seattle USA have mastered process for each and every medical condition and removed non value added waste. The result is a hospital that maximizes patient contact time and provides all the facilities necessary for the doctor to do their job. The patients are happy and the consultant surgeons get home earlier because their clinics and theatres operate efficiently.

The cost to the patient is invisible. It is the



Figure 1 Patient Value Equation - value is defined by Quality divided by Cost

David O'Regan

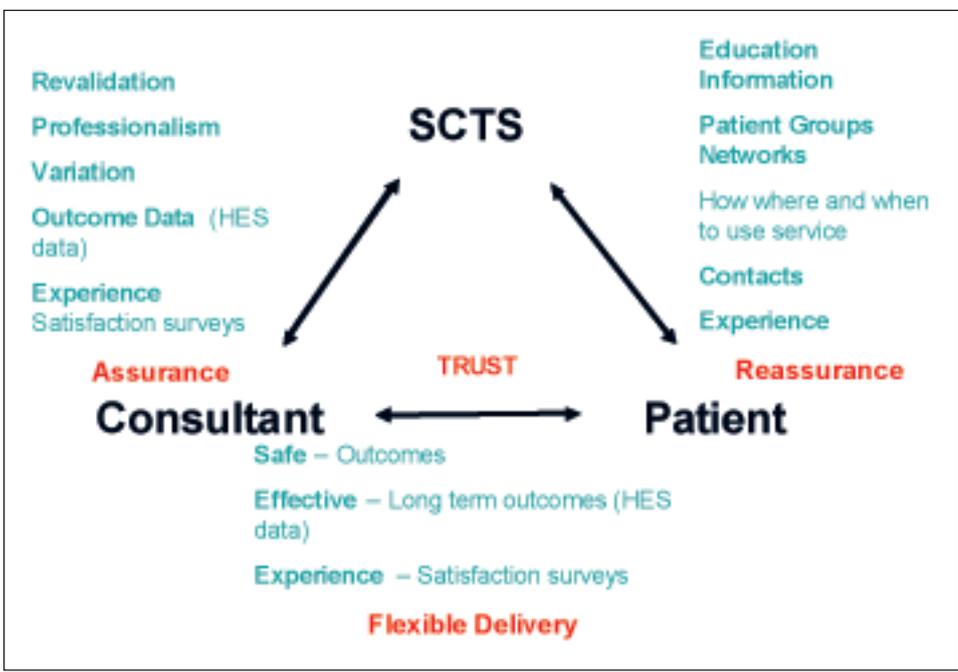


Figure 2 The Patient Service Triangle

are run by trainees alone - past research has determined that if in doubt bring the patient back - this is a waste of resource and a waste for the patient. Is it not possible to say - no consultant no clinic?

The interdependency of the Consultant, Patient and the Society is represented in a service triangle with Trust Assurance and Reassurance being interdependent as depicted in figure 2.

The cardiologist must also be regarded as a customer rather than a partner (figure 3). This paradigm brings new thinking to their role and reinforces the concept of multi disciplinary clinics. Our President is to be congratulated in championing the efforts of establishing rigorous guidelines that should direct our practice and those of the cardiologists. Creating value can only be achieved by rigorous application of evidence based practice and collection and sharing of knowledge of conditions where that evidence is not so clear. Our national and international networks and society go a long way in sharing that knowledge - figure 3.

cost of inconvenience, the cost of time, waits, delays and distress caused by a service that is not necessarily designed with them in mind. The flow of the service will be improved with one stop shops and proper discharge planning - papers to this effect were presented at the 2011 SCS meeting.

The highlighted areas of the patient value equation are within our remit and not those of managers. Change will not come from top down control but from within our society and ourselves. We have to want to do it - a realisation by all members that we can and should design a better service by putting our patients at the centre of our endeavors and design services that meet the challenges of the future. If we expect supermarkets and other service sectors to be open when we finish work, it is not unreasonable to foresee in the future that our patients, our customers, will expect the same from us. Would it not be more useful and more agreeable if we start to think of this ourselves? Indeed, evidence tells us that systems designed and inspected by the people who do the work are more successful.

The fundamental principle in the service industry is to front load with the expert.

The expert in our specialty is the consultant, and yes, we do deliver and have embraced the principle of a consultant led and delivered service, but does this principle encompass all activities to ensure that our patients receive expert decision making at all times throughout their pathway. Putting the consultant on the front line reinforces this principle. It will not only improve the delivery of our service and remove waste but improve training opportunities. How many clinics

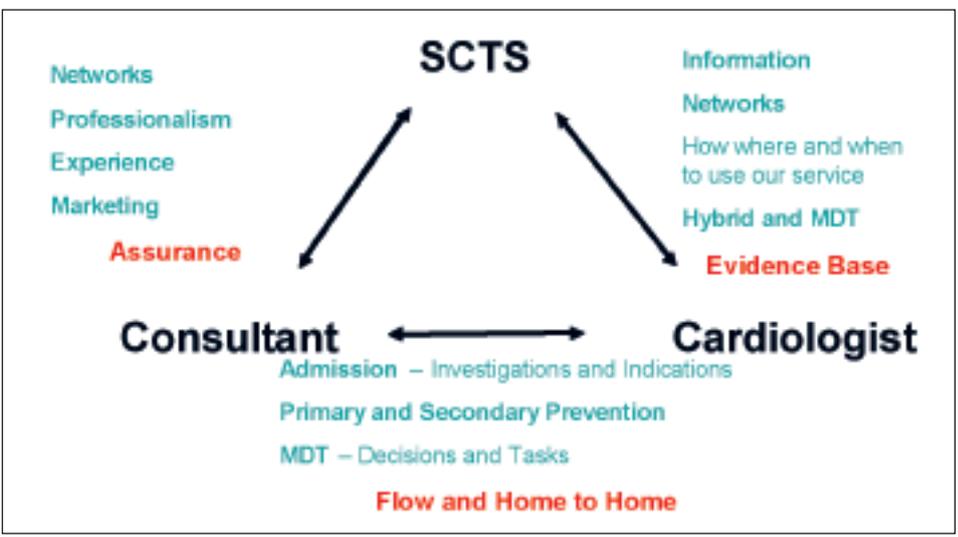


Figure 3 The Cardiologist Service Triangle

The SCTS serves *who first?* continued

But as we enter a new era there is a third customer on the horizon. GP commissioning means that a general practitioner is now to be regarded as an important customer (figure 4). Using this paradigm, it is easy to see how we can help GPs and GPs can help us. A home-to-home approach will realise and create value for each and every medical condition. The obvious area of synergy is to be found in building the medical record. This has to be better than the often brief referral encapsulating a description of an angiogram without any mention of other systems or social circumstances. The latter we are all aware is as an important dimension in the decision making process of whether to operate or not – would it not be better that the notes are started by the GP completed by the cardiologist and then presented for consideration for surgery, This would constitute a comprehensive well documented consultation.

Another GP-surgeon collaboration is the practice of prevention. Primary and secondary prevention for heart disease means that together we need to focus on optimal treatment for high blood pressure, high cholesterol and diabetes. We can realise savings and create value by sharing best evidence of treatment of these conditions and ensuring that patients arriving in hospital are optimally treated for these conditions. Likewise on discharge our recommendations are continued and followed up. A partnership with the general practitioners will also mean that we will be able to find out what happens after discharge. Longer term outcomes such as re-admission rates and complications will become a reality. More

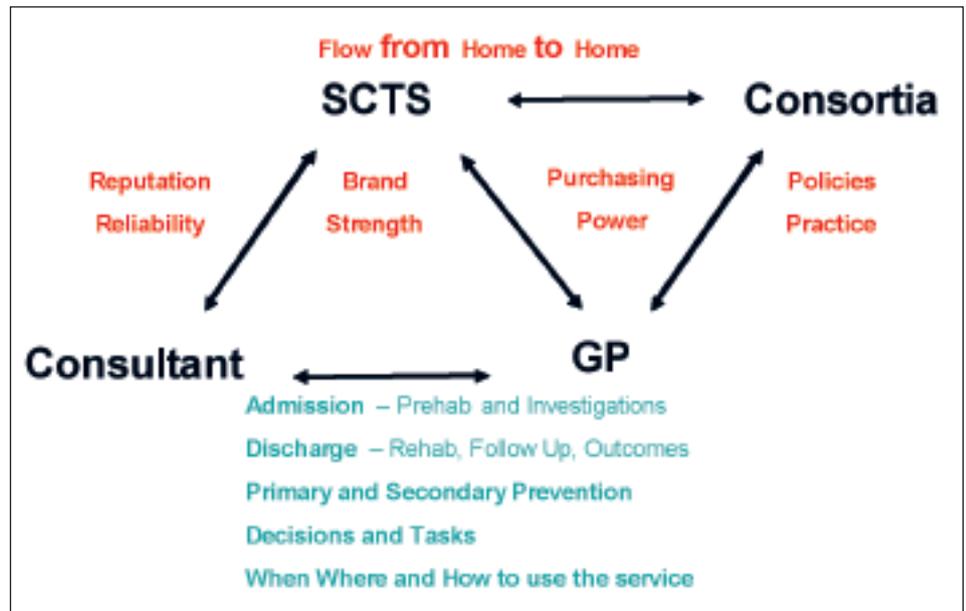


Figure 4 The GP Service Triangle

importantly we can then begin to get a better picture of the patient's experience, outcomes, functional status and quality of life. This data needs to inform the process through established feedback loops - figure 4.

The new era is presenting fantastic challenges. The Society, however, is effectively meeting many of these challenges whether it realises it or not. Business thinking and adopting thinking from the service industry will bring coherence to our endeavours. We need to reflect on own service encounters and apply them to our specialty. Above all we need to start thinking 'Who is our customer?' The SCTS can and should continue to serve first.

Addendum - The Satellite meeting at the SCTS was attended by 20 business thinking cardiac surgeons. Many have MBAs and many more are considering doing an MBA. The UK Association of NHS Medical Executives (www.UKAN.me) pronounced [you can] has been established because together we will shape the business of health care is. I believe the SCTS - can!

David J. O'Regan
MBA MD FRCS C-Th
Twitter:@David_ukan

Other Interests

- 1) Sam Nashef has begun compiling Crosswords for the Guardian newspaper, starting May 2011. Look out for his crosswords on Thursdays.
- 2) Shyam Kolvekar has been a medical advisor for over 300 episodes of "Holby City" (televised every Tuesday 8 pm, BBC)
- 3) Rob Lamb's team has been selected to run a course at the Olympics 2012 in Weymouth. (More details next time).

The UK Cardiothoracic Research Collaboration

*Aaron Ranasinghe
on behalf of the UKCRC*

Setting up and running research can be difficult. The ideas for studies are in the main relatively simple. However, after the power calculation that tells you that you need to recruit an impossible number of patients for your "hard endpoint", you then compromise so that you can get a workable number. You are next faced with a number of hurdles including writing (and rewriting) the protocol, coming up with a statistical analysis plan, obtaining funding, ethics and research and development approval. By the time you have been through all of this, you may be 12 months down the line and not even got close to recruiting your first patient. Wouldn't it be a good idea if there were some people who could help? This is where the United Kingdom Cardiothoracic Research Collaboration (UKCRC) comes in.

The idea for the UKCRC was based on an idea set up by the general surgical trainees in the West Midlands for two primary reasons: Trainees were interested in finding the answer to questions, but the studies had not been done because of the sample size required. And many had not undertaken a formal period of research and found that they were short of publications and presentations when it came to the consultant job interview.

With these aims in mind, they constructed the West Midlands Research Collaborative a trainee-led research network within the West Midlands set up by the trainees themselves with the active support of their consultants). The collaboration has support from the University of Birmingham Clinical Trials Unit and the Primary Care Clinical Research and Trials Unit. It capitalises on the natural network formed by surgical trainees rotating between hospitals in the West Midlands and since its inception it has allowed them to set up eight research projects. These include retrospective database studies in association with the West Midlands Cancer Intelligence Unit (CANOES and CANOES II), a study on the impact of shift work on Foundation Year trainees (SWIFT) and a prospective randomised multi centre observer-blinded trial to reduce surgical site infection (ROSSINI). Note that it's not only the Cardiologists that can come up with fancy acronyms.

The concept of research collaboration within their specialty has been successful and there is no reason why a similar model albeit on a national scale could not work (with the correct support) for cardiothoracic trainees.

There are a number of questions that spring to mind immediately:

Who will run the collaborative?

There are a number of administrative positions within the collaborative (chairperson, treasurer etc). These are open to all trainees and be for a fixed term to allow rotation of the administrative committee.

Who will supervise the collaborative?

All consultants who participate with trainees in UKCRC projects will naturally retain a supervisory role over their own trainees. All projects would be undertaken under both national and local research governance legislation with appropriate ethical committee and R&D approval prior to starting a project.

Who is supporting this group?

We hope that all consultant cardiothoracic surgeons within the UK and Ireland will support this initiative. Specifically, Professor Tom

Treasure has kindly agreed to act as a steward to the group and the President of the SCTS has given backing to the collaborative. With multi-centre trials we will engage the support and expertise of clinical trials units.

What about the Thoracic Research Collaborative?

This is a separate group to the Thoracic Research Collaborative. Whilst these collaboratives are separate bodies, there is a clear potential for overlap of ideas and for collaboration between the two groups.

What do the trainees get from this?

Trainees would gain:

- 1 A share in better research, bigger "N", more representative practice.
- 2 Shared experience with project proposals, grant writing, ethics submission, presentation skills and manuscript writing (defined groups would work on each of these areas)
- 3 Strengthening of CVs with both presentations and publications
- 4 Networking with trainees from other regions
- 5 A share in projects that can run over more than one year and in more than one unit.

What do Consultants get from this?

1. Bringing research into local units which want to participate but do not at present have the infrastructure or appropriate support to have dedicated research teams
2. A chance to scale up individual or unit level research projects
3. Publications
4. Networking

How will proposals be chosen?

An annual call for proposals will be announced; following submission all proposals will be anonymously assessed and one or two projects chosen per year. This would allow for a number of active projects to be running whilst others are being set up, hopefully allowing for a constant stream of projects.

Who will present the data?

Each project will have a lead. It is envisaged that the lead for that project would become the lead presenter of the work but if there are more outings others can take their turn to present. All work would be presented on behalf of the UKCRC.

Who will be listed as authors on manuscripts?

Authorship will be from the UKCRC with all collaborators and their Units credited (as is the norm for multi-centre trials). Criteria for authorship will be agreed in principle at the outset so that there is transparency as to how authorship is credited.

We hope that both consultants and trainees reading this article will support such an endeavour and will contact us with any direct questions/suggestions.

UKCRC currently consists of Joel Dunning, Neil Howell, Aaron Ranasinghe and Neil Roberts

Cardiothoracic Representative for the Wessex Shadow School of Surgery

Hunaid A Vohra

Purpose

The participation of trainees in the development and evaluation of curriculum enhances delivery of training and the quality of milieu in which learning objectives need to be accomplished. Encouraging trainees to give objective and practical view-points can however, be difficult, perhaps due to the lack of a formal body to which trainees are accountable to and because trainees may feel that their comments are ignored. Cardiothoracic trainees may also feel that providing 'negative feedback' may impact future training opportunities. Hence a structure which enables trainees to feel confident to provide feedback as well as one which encourages their involvement with the development of training environments at a regional level would be welcome.

The recent introduction of the Wessex Deanery School of Surgery promises to provide an excellent prospect of developing a pioneering way of ensuring trainee participation into deanery and specialty affairs. A Shadow School of Surgery which mirrors the main Surgical School has been developed to provide a forum for surgical trainees to discuss matters intrinsic to being a surgical trainee in Wessex. The elected members of the Shadow School board endeavour to ensure pro-active trainee involvement with both surgical specialty and deanery issues and facilitating the delivery of trainee's opinions to the main Deanery School of surgery. The Shadow School is accountable to the Head of the School of surgery and the postgraduate dean.

The Board

The board of the Shadow School of Surgery has a similar composition to the main School of Surgery board. Each of the ten surgical sub-specialties is represented by an elected trainee who is interested in training and educational matters. The appointment is supported by the training

programme director (Wessex Cardiothoracic TPD: Mr Sunil K Ohri). There is also an academic training representative and a Core Training Representative on the board. The board has an external lay representative appointed by the dean and a member of the deanery. Finally, there is a deanery appointed 'Chair' who is directly accountable to the head of the main school and who is also the trainee representative on the main School of Surgery board.

Terms of Reference

The Shadow School of Surgery provides a point of reference for all surgical trainees within Wessex from each of the subspecialty areas. The Shadow School:

- ensures high quality training within the deanery
- is responsible for the propagation of information from the School of Surgery and regional STCs
- ensures representation on local training committees
- ensures there is a point of contact for each hospital
- develops a trainees' website in conjunction with NESC School of Surgery site
- maintains a trainee database
- produces a newsletter for surgical trainees
- is involved with regional teaching that facilitates training and logbook completion

The sphere of activity of the shadow school of surgery board is to discuss the themes that the main school deals with. It seeks to achieve this by incorporating the deanery functions of:

- Teaching and learning
- Managing training programmes and posts
- Curriculum implementation
- Trainee selection
- Assessment of progress (RITA / ARCP)

- Workplace based assessment
- Quality assurance and evaluation
- Educational research

My Role

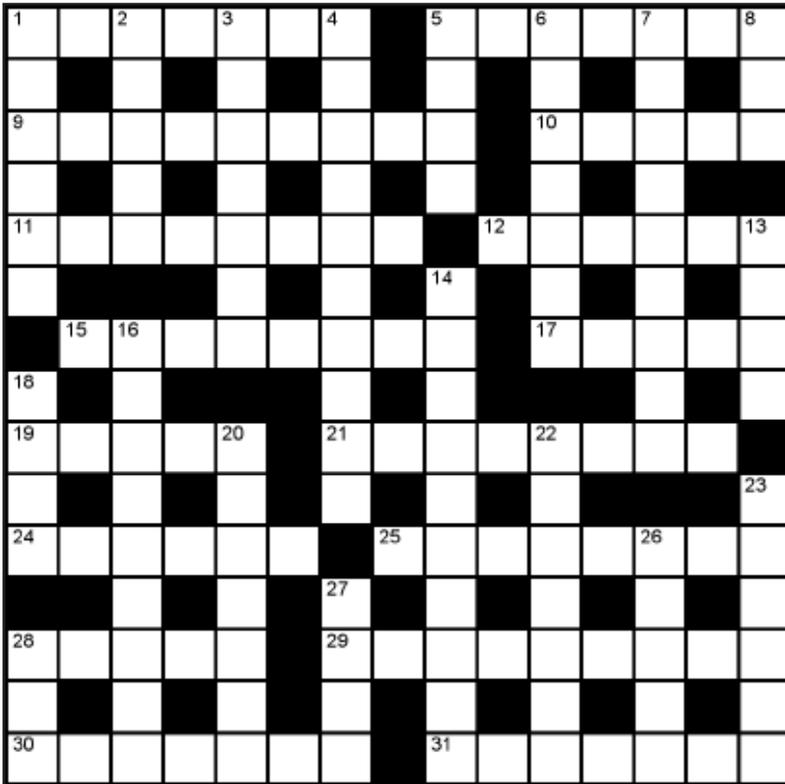
Being appointed as the Cardiothoracic representative on the Shadow School of Surgery board, I have a commitment to ensure high standards of cardiothoracic education and training at programme and hospital level are met. This exciting new venture enables me to influence cardiothoracic workforce needs and champion patient safety by contributing to the development of training programmes that ensure the training of fit for purpose cardiac and thoracic surgeons. The fostering and development of trainee-trainer relationship is another crucial issue which is generally poorly handled in our speciality and needs to be addressed. For those trainees interested in pursuing academia, a fertile soil tailored to their requirements, needs to be cultivated. The provision of high-quality regular consultant-led didactic/interactive teaching should be the aim to ensure a high pass rate at the Inter-collegiate FRCS (CTh)

Appraisal

The Shadow School of Surgery undergoes regular evaluation as part of the Deanery's Quality Assurance process to determine whether its establishment has brought a change. The evaluation process involves Head of the Surgical School, Main School Board, members of Shadow School Board and the Wessex surgical trainees. This aims to identify whether there has been an improvement in the opportunities to provide feedback and influence training as a result of the development of the Shadow School.

the crossword

by Sam Nashef



Across

- 1/9 Fruit as 8 the 19 of 17 21 (7,3,6)
 5 Birds in smart disguise (7)
 9 See 1
 10 17 feature, type I disorder (5)
 11 So many grapes are not picked (8)
 12 See 28 Down
 15 Remote object of which you owe 5 as 8 the 19 of 17 5ac (8)
 17 Stain-free character (5)
 19 Inventor's clangers (5)
 21 After 17, church where a hundred replaced drug in fire and water (8)
 24 Take in Arabs, or Brits admitted (6)
 25 Playing Moon River right away for no picky eater... (8)
 28 ... starts to overeat big entrees, sweets, etc and ends so (5)
 29 Suggestive comments send union round the bend (9)
 30 Legendary hairdresser somehow allied with Hungarian capital (7)
 31 Stitches torn trouser suit having left riot (7)

Down

- 1 Pop a question that's partly unclear (6)
 2 Assistants with funny ideas (5)
 3 Most dull eyes for compiler in grit (7)
 4 Waterside dump in London (10)
 5 How King Edward may be served with sausages (4)
 6 Salesman swallows and regurgitates (7)

- 7 Get laid if drunk (present perfect) (5,4)
 8 State for example (3)
 13 Snowman rising in white yuletide scene (4)
 14 Deals with meat and greens? (10)
 16 Compiler waves after a 50-50 general reassurance (3,2,4)
 18 In Sweden they rock up and down (4)
 20 Fantastic as ruler (7)
 22 Famous compiler's in part of hospital (7)
 23 Count the poles in misleading cues (6)
 26 Organisation command (5)
 27 Loaded what I need to grow before settling, 8 the 19 of 4 (4)
 28/12 Court whose 19 demand payment date (3,6)

Send your solution to:

Sam Nashef, Papworth Hospital, Cambridge CB23 3RE or fax to 01480 364744 by 31 December 2011.

Solutions from areas over 10 miles from Cambridge will be given priority.

Last issue's winner:

The winner for December 2010 is **Ted Brackenbury**, Edinburgh.



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STANDARDS ARE NOT.



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