Issue 13
January 2023

the bulletin

Society for Cardiothoracic Surgery in Great Britain and Ireland

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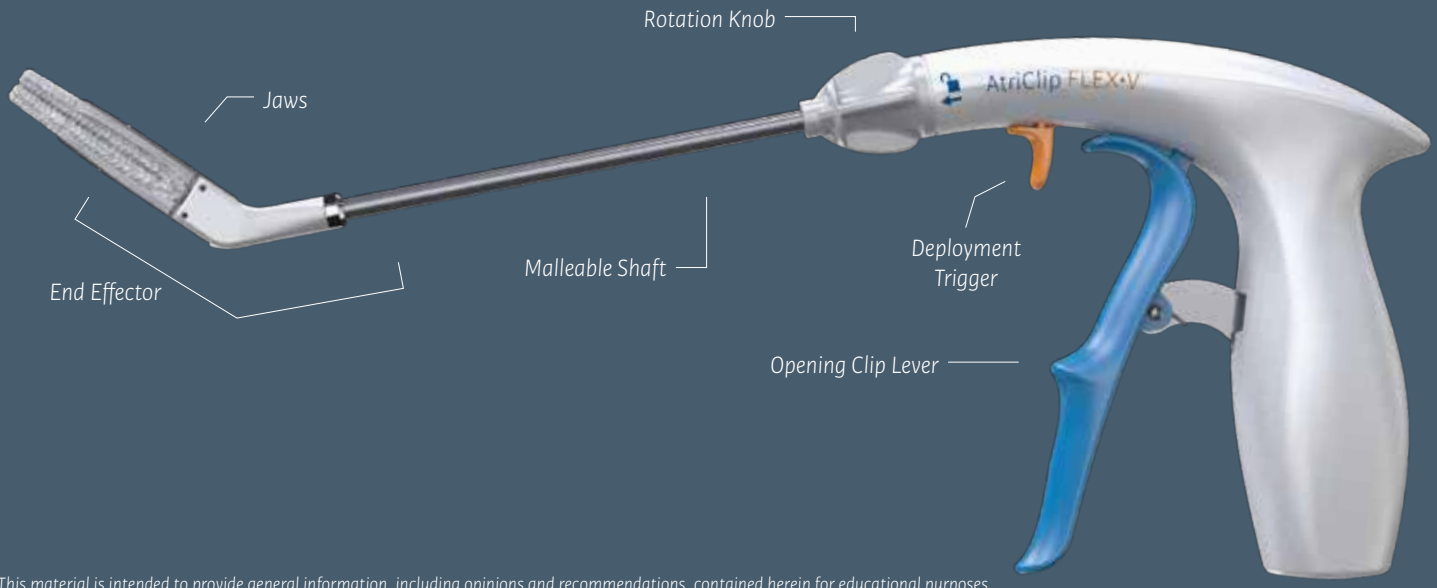

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Please review the Instructions for Use for a complete listing of indications, contraindications, warnings, precautions and potential adverse events prior to using these devices.

US Only: *The AtriClip LAA Exclusion System is indicated for the occlusion of the heart's left atrial appendage, performed under direct visualization and in conjunction with other cardiac surgical procedures.*

Direct visualization, in this context, requires that the surgeon is able to see the heart directly, with or without assistance from a camera, endoscope, etc., or other appropriate viewing technologies.

Rx Only.

MKT-2439B-G

AtriCure

In this issue ...

the bulletin
Society for Cardiothoracic Surgery in Great Britain and Ireland

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Trust at Heart

We look forward to seeing you in March at SCTS 2023

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From the Editor

Indu Deglurkar, Publishing Secretary, SCTS

"You can never cross the ocean until you have courage to lose sight of the shore."
– Christopher Columbus

As we embark into the New Year embracing the challenges that lie ahead, we can reflect on a positively eventful 2022 and some return to normalcy. Simon Kendall stepped down as the President after leading SCTS through very difficult times and passed on the baton to Narain Moorjani at the well-attended BORS meeting in September 2022. Simon's superb and compassionate leadership during the pandemic will be etched in the history of SCTS. Isabelle Ferner was given a warm send off after 22 years in the SCTS. Hearty congratulations to Narain as the new President of SCTS and Aman Coonar as he steps into the role of President-Elect in March 2023.

Narain Moorjani in his first article as the President outlines the challenges that our specialty faces with waiting lists, describes the widening participation and outreach programme and the much needed Mental Health toolkit being developed by the SCTS. Rana Saeed outlines the recent SCTS Constitutional changes and the ongoing discussions that are underway.

Jules Dusseks's article "Surgeons twiddling their thumbs" and Rob Lamb's article "Once upon a time..." give us an insight of the SCTS over two decades ago and a candid recollection of events and the changes that were initiated. Undoubtedly, Isabelle's appointment during their tenure as Past President and Honorary Treasurer was pivotal in bringing about a solid administrative epicentre for the SCTS. Their judgement and the meritorious appointment has certainly stood the test of time. There has been a steady increase in the number of articles submitted to the Bulletin over the years and the issue is replete with a number of reports from various committees and articles from the membership.

"The lack of compassion in the system and the personal and professional stigma associated with mental illness deters staff from seeking help. Our strategy should be to recognise mental health issues, provide timely help and eradicate the powerful stigma and embarrassment attached to it. Staff education and a psychologically safe workplace will enable colleagues to speak up and seek help with meaningful access to care for a sustained period."

I would like to focus and draw your attention to the mental health & well-being article by Sarah Murray & colleagues. Mental health problems are age old but has risen to critical state. We work in stressful, high pressure settings with limited time and resources and tackle stress differently. The high rate of mental health issues with low percentage seeking help due to concerns about self- image, registration to practice, career implications and confidentiality issues. The ONS reports 733 suicides amongst health professionals between 2011-18 in England & Wales alone. The incidence of suicide is 2-5 times that of the general population. In addition to mental illness, the way health professionals are treated with unique issues related to their job illustrates the damaging nature of complaints and regulatory processes. The lack of compassion in the system and the personal and professional stigma associated with mental illness deters staff from seeking help. Our strategy should be to recognise mental health issues, provide timely help and eradicate the powerful stigma and embarrassment attached to it. Staff education and a psychologically safe workplace will enable colleagues to speak up and seek help with meaningful access to care for a sustained period.

The revenue for the Bulletin is being raised by the SCTS for the first time with support from the Industry & I would like to thank Tilly Mitchell, Emma Piotrowski and Maika Jimenez, the editorial committee and our sponsors. Emma, Tilly & Maika have effortlessly risen to the challenges in their very first venture. The Open Box Media Team & Rachel Woolf have remained stellar and tirelessly worked through these transitions. It has been an absolute pleasure to work with Simon Kendall & Isabelle Ferner over the years and we wish them the very best.

Happy 2023 to all of you... ■

From the President

Narain Moorjani, SCTS President, Consultant Cardiac Surgeon, Royal Papworth Hospital, Cambridge

Following the completion of his term of office, I would like to thank my predecessor, Simon Kendall, for his outstanding contributions to the SCTS and to the specialty in general. Simon has been heavily involved in the Society for the past 20 years, initially as a Trustee, then as Meeting Secretary and Honorary Secretary, and most recently as President-Elect and President. He has contributed so much to cardiothoracic surgery to ensure that patients are put at the centre of decision-making and that all members of the team who deliver care to patients undergoing cardiothoracic surgery are valued and respected.

It is a real privilege and honour to have been elected as President of the SCTS to continue the great work of all my predecessors and also to tackle the challenges that lie ahead. I am very fortunate to be working with a committed and dedicated SCTS Executive with whom I will be delivering our agenda over the next few years to strengthen cardiothoracic surgery for the future.

The major current challenge that we all face is the increasing number of patients waiting for cardiothoracic surgery following the COVID pandemic on the background of staffing shortages and reduced resources. The SCTS will continue to fight to prioritise care for our patients at a national level, through discussions with the commissioning groups and the Royal Colleges of Surgeons, as well as promote opportunities to streamline our practice through quality improvement programmes, including enhanced recovery and day of surgery admission. We also all need to be mindful of what our surgeons in training have experienced over the past few years and ensure that all potential training opportunities are realised alongside the recovery plan.

In parallel, we shall continue to improve outcomes for our patients. This will be achieved through the initiatives that we have already established or will be introducing, such as ensuring that innovation and the adoption of novel techniques can flourish, developing access to national audit data for use by the SCTS and its members to drive improvements in care, and supporting the development of a world-leading SCTS-driven national research programme. SCTS Research-led Priority Setting Partnerships have agreed on the research priorities of the specialty and there is a great opportunity for the UK cardiothoracic community to participate in high-quality research with the potential to influence directly the clinical care we deliver. We encourage all members of the cardiothoracic surgical community to contribute to clinical research to ensure that the specialty evolves.

> **"It is a real privilege and honour to have been elected as President of the SCTS to continue the great work of all my predecessors and also to tackle the challenges that lie ahead."**

SCTS Education continues to improve the broad portfolio of training courses and travelling fellowships offered to support all cardiothoracic surgical practitioners. As well as revising the training courses to align with the new cardiothoracic curriculum, there are new courses offered, or in development, targeted at Trust-Appointed Doctors (TAD), nurses & allied health professionals (NAHP), and consultant surgeons.

In addition, the SCTS is striving to enhance the working lives of the practitioners who deliver care to our patients by reinforcing the importance of a supportive working environment and increasing opportunities for all to succeed in cardiothoracic surgery. In response to the increasing pressures of working in the NHS, the SCTS is developing a mental health and well-being toolkit to support its practitioners. The importance of an awareness of team well-being and looking after those around you is highlighted in the insightful article from the SCTS Mental Health and Wellbeing Working Group (see page 62), which emphasises what can be done to support our colleagues and signposts members to the resources available on the SCTS website. We plan to introduce initiatives to provide a more supportive work environment for parents in cardiothoracic surgery, as we understand the challenges of modern-day family life, often with two working parents and young children.

To ensure all cardiothoracic surgical practitioners have a voice in how the Society is being run, we are reviewing our constitution with plans to introduce an NTN Trustee, NAHP Trustee and TAD Trustee, as well as making the Communication Secretary an appointed Trustee. The proposal will be put to the membership at the next Annual Business Meeting in March 2023.

As part of our Equality, Diversity & Inclusion strategy, we have launched the Widening Participation and Outreach Programme to reduce the barriers that potential entrants may face when considering a career in cardiothoracic surgery. As well as the medical student

mentorship programme, we are setting up a portfolio of work experience placements, webinars, workshops at local cardiothoracic units, talks at individual schools by cardiothoracic surgeons, bursaries and travel scholarships, and online resources to encourage those who have never considered cardiothoracic surgery to look at the specialty as a possible career. We must attract the most motivated and enthusiastic students to the specialty, irrespective of background, to ensure a vibrant future for cardiothoracic surgery.

Importantly, given the current environmental challenges we face as a society, it is essential for the practice of cardiothoracic surgery to become more sustainable and contribute to the changing world around us. The SCTS is working hard with the Royal College of Surgeons and other key stakeholders to write best practice guidance for surgical teams to develop the knowledge and skills needed to introduce sustainable models of care within their own unit.

"The SCTS will continue to fight to prioritise care for our patients at a national level, through discussions with the commissioning groups and the Royal Colleges of Surgeons, as well as promote opportunities to streamline our practice through quality improvement programmes, including enhanced recovery and day of surgery admission."

Finally, I wanted to bid farewell to Isabelle Ferner who has been at the heart of the Society for the past 22 years. Isabelle has been there from the start of the SCTS Administration, when she was appointed by the then SCTS President (Jules Dussek) and Honorary Treasurer (Rob Lamb) in 2000 (see page 54). It is amazing how the Society has evolved during her years at the helm, and we will be forever grateful for all that she has contributed. Whilst Isabelle will leave in place a fantastic team in SCTS Administration, she will be sorely missed. Thank you so much for all that you have done for the Society, and we wish you all the best for your new adventures. ■

From the Honorary Secretary

Rana Sayeed, Honorary Secretary, Consultant Cardiac Surgeon, John Radcliffe Hospital, Oxford

The SCTS is the professional society for all healthcare professionals involved and interested in cardiothoracic surgery. The membership has grown to over 1500, including consultants, NTNs and Trust-appointed doctors (TADs), nurses and allied health professionals (NAHPs), and medical students. The Society's surgical sub-specialties and other joint activities are represented by fifteen sub-committees and working groups with representation from all membership categories: almost one-tenth of the membership are actively involved as Executive or sub-committee members. The impressive commitment and dedication of its members contribute to the Society's success in achieving its aims of promoting excellence in the practice of cardiothoracic surgery, encouraging innovation and undertaking research, and educating the public.

New appointments

There have been important changes in leadership roles over 2022 as officebearers have reached the end of their terms of office. I join Narain Moorjani in thanking Simon Kendall for his extraordinary contribution to the SCTS over two decades. I look forward to working with Narain, Aman, our new President-Elect, and the rest of the Executive in implementing our plans over the next few years.

There have been new appointments within the Executive: Elizabeth Belcher as Education Secretary; Mobi Chaudhry as Perfusion representative; Uday Trivedi as Audit sub-committee co-chair; and Bassem Gadallah and Walid Mohamed as Trainee representatives.

I would like to thank Enoch Akowuah and Aman Coonar, who will demit as elected Trustees in March, and welcome their successors, Attilio Lotto and Karen Redmond, who will start their three-year term as Trustees.

The Society is supported in all its activities by our excellent administration team based in the SCTS office at the Royal College of Surgeons. We bade farewell to

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Isabelle Ferner at the end of October (see Rob Lamb's article on page 54 for a description of her pivotal role in the SCTS's development), and Emma Piotrowski has been appointed to replace Isabelle as Society Administrator & Conference Organiser. We welcomed Mara Banuta as Education Administrator and María del Carmen Jiménez Blanco (Maika) as Conference Organiser & Finance Coordinator on a 12-month fixed-term contract to cover Tilly Mitchell's maternity leave.

Sub-committee co-chairs

Each of the fifteen sub-committees and working groups has two co-chairs, one from the sub-committee and one from the Executive. The roles of the Executive co-chair are to allow two-way feedback to and from the sub-committees to the executive and provide oversight at sub-committee meetings. The current sub-committee Executive co-chairs are below; these will change after the new President-Elect takes office following the Annual Meeting in March.

Increasing representation

One of Society's current aims is to improve professional representation to reflect the increasingly multi-professional delivery of modern cardiothoracic care.

The Board of Representatives meeting at Woburn House in September was the first BORS meeting with multi-professional representation from units. There were about 140 in-person and remote delegates – consultants, NTNs and TADs, and NAHPs – from all the cardiothoracic centres in the United Kingdom and Ireland.

More importantly, we have proposed changes to the Society's Articles of Association (the 'constitution') to widen representation of the membership within the Executive. The President first presented these proposals at the Annual Business Meeting in March 2022; the proposals have subsequently been discussed amongst the Trustees over the summer, at BORS in September, and at the Executive meeting in October.

The two main proposals that have been agreed upon after this extensive consultation are:

- To create three additional non-consultant trustees, one to represent and be elected by i) NTNs, ii) TADs, and iii) NAHPs.
- To make the Communication Secretary an appointed trustee.

These proposals would increase the number of trustees from 11 to 15 and allow the representation of NTNs, TADs, and NAHPs at the highest level of SCTS decision-making. These proposals will be tabled as resolutions to be voted on by members at the Annual General Meeting next Spring. The members will have opportunities to engage with the process and discuss in the webinars, which are being organised.

In addition to these main changes, we have formalised the eligibility criteria for trustees and other senior officers, such as good professional standing and conflicts of interest, and agreed on a social media policy to cover i) the SCTS's use of social media to promote its activities and ii) members' responsibilities on social media to avoid reputational harm to the SCTS.

The Society depends on its members' active participation for its success. Please contribute as much as possible by attending our meetings, voting for your representatives, and considering a role within its sub-committees and Executive. We also look forward to meeting you all in your individual units as part of the unit engagement, as well at the annual meeting in Birmingham. ■

	Co-chair(s)	Executive Co-chair
Adult Cardiac	Enoch Akowuah	Narain Moorjani
Thoracic	Aman Coonar	Rana Sayeed
Congenital	Andrew Parry	Amal Bose
Transplantation	Steven Tsui	Rana Sayeed
Research	Mahmoud Loubani Eric Lim	Cha Rajakaruna
Education	Debbie Harrington Elizabeth Belcher	Amal Bose
Audit	Uday Trivedi	Rana Sayeed
Innovation	Hunaid Vohra	Narain Moorjani
Communication	Sri Rathinam	Rana Sayeed
Equality, Diversity & Inclusion	Indu Deglurkar	Narain Moorjani
WICTS	Karen Booth	Narain Moorjani
Patient Safety	Andrew Parry	Sri Rathinam
Professional Standards	Sarah Murray	Andrew Parry
NAHP	Bhuvana Krishnamoorthy	Sri Rathinam
Meeting	Cha Rajakaruna	Sri Rathinam

SCTS ANNUAL MEETING 2023
19TH - 21ST MARCH – ICC BIRMINGHAM

INTERNATIONAL GUESTS

Isabelle Schmitt–Opitz (ESTS President) • Nasser Altorki • John Puskas • Joseph E. Bavaria • Sheila O'Keefe–McCarthy • Martin Czerny

SCTS UNIVERSITY

Cardiac & Thoracic Surgery Educational Sessions by International and National Leading Experts • Lung volume reduction surgery • Quality in coronary artery surgery • Technical tips in major aortic surgery • Bioprosthesis in young adults for acquired valve disease • Perioperative SACT for resectable lung cancer

MAIN MEETING PROGRAMME

Plenary Sessions – New developments in national audit • Sustainability and greener surgery • Celebrating 10 years in SCTS Education • Research: A trial for every patient/a patient for every trial • Scientific Abstracts & Keynote talks • Industry Exhibition & Symposiums • WiCTS sessions inspiring membership • Late breaking trial launch announcements

CT NURSE & ALLIED HEALTH PROFESSIONALS FORUM

University Day featuring: Wetlab • NAHP Research • AHP Updates
Meeting Theme: Excellence in Patient Care – National & International Perspectives

SOCIAL EVENTS

Sunday 19th March – Welcome Reception in Exhibition Hall
Sunday 19th March – Pub Quiz from 8pm–9:30pm
Monday 20th March – SCTS Annual Dinner at Macdonald Burlington Hotel

Up to 18 CPD points

Registration is now open. Early bird discounted rates until 31st January 2023. To Register or view the detailed programme please visit www.scts.org **#SCTS**

SCTS
Society for Cardiothoracic Surgery in Great Britain and Ireland

SCAN ME

Supporting Sustainability

the icc birmingham

SCTS conference report

Cha Rajakaruna (Consultant Cardiac Surgeon, Bristol Royal Infirmary)
SCTS Meeting Secretary, on behalf of the meetings team

Back to old ways and back to normal! The 2023 SCTS annual meeting is planned as an in person meeting at the ICC Birmingham from 19th - 21st March.

The University day has an exciting line-up of two parallel cardiac sessions. The coronary sessions will be on quality improvement during coronary surgery and technical tips. The British Heart Valve society will host the valve sessions with a focus on biological valves in the young person, options for the second and third interventions. Major aortic surgery sessions will have a feast of 'how do it' lectures from leaders in the field. The thoracic sessions will be headlined by lung volume reduction surgery with special guests from AATS and ESTS. Further sessions will deliver innovation in thoracic surgery, treatment of early stage lung cancer and a focus on advances in pharmacology treatments.

Nursing and allied health care (NAHP) colleagues have plans for an interactive, informative and educational three days at the annual meeting. The focal theme of the NAHP branch of the meeting is 'Excellence in patient care – National and International perspectives'. There is an additional spotlight on 'Mental health and well-being'. In support of this important subject, there will be an area dedicated at the meeting to 'meet, reflect and share'. The University day will begin with an all day cardiothoracic Wetlab. Along with NAHP delegates, the Wetlab will host trainees and student delegates. This year a parallel NAHP stream is organised specifically highlighting updates on cardiothoracic Research, Physiotherapy and Perfusion. There will be additional sessions focused on student engagement with a 'question time' style panel hosting the student delegates followed by Pat Magee student abstract presentations. The other two days of the meeting will have a lively mix of NAHP abstract presentations along with an impressive line up of key note speakers. For the first time there is an entire session planned to promote international engagement. NAHP representatives from all continents of the globe will join to share their experiences and vision. It would be the beginning of building international relationships within the SCTS NAHP communities and promote shared learning. The popular 'Team of the year' award is set to return again in 2023. The applications are open and we hope this will continue to promote healthy competition and shine a light on inspiring cardiothoracic multi-disciplinary teams working all over Great Britain and Ireland.

On Monday, the theme of the main Plenary will be around sustainability and greener surgery, with an interesting line up of inspirational national speakers to influence our Society. With sustainability at the forefront, the Meetings team are taking steps to ensure this meeting is as sustainable as possible, with eco-friendly recycled lanyards, textile advertising banners and digital signage, without a non-recyclable bottle or cup insight! The ICC Birmingham has a passion for sustainability and it is embedded into all daily operations, from sourcing food and beverages locally to the use of smart meters and carbon off-setting as part of their energy efficient drive and a 'waste not, want not' approach.

> **"We look forward to welcoming our members and guests in person to SCTS 2023 in Birmingham."**

We look forward to honouring Professor John Wallwork with the SCTS 2023 Lifetime achievement award and further plenary sessions are planned to show case UK multicentre research and 10 years of SCTS Education. The main meeting scientific abstract sessions will dominate the rest of the time with six parallel sessions delivering abstract presentations with special keynote lectures in the various subspecialties.

Further to the positive feedback received from the childcare facility that was offered at last year's meeting, this will of course be offered again and we do hope delegates take advantage of this on-site facility.

The Gala dinner is to be held at the Macdonald Burlington hotel ballroom, with a 1920s 'Peaky Blinder' theme, where the President will present the awards for the prize winners from 2022. We look forward to hosting our international speakers and say a special and final goodbye to Isabelle Ferner, who left the SCTS team in October 2022 after 22 years of service to the society's members and their patients.

Our industry partners are once again pledging their support to our society exhibition and various sponsored sessions. The President elect will host delegates at a welcome reception to mark the official opening of the main meeting on Sunday, 19th March at 5pm followed by Mr Bhudia's famous pub quiz!

Finally, to the Meeting's team news! The team are delighted that Emma Piotrowski has joined us from the education stream to take over the role of Society Administrator and conference organiser. The team would like to thank Tilly Mitchell for her work in 2022 as she goes on maternity leave. We welcome Maika Jimenez who will cover Tilly's absence. Ms Carol Tan, Consultant Thoracic Surgeon from St George's Hospital, London has joined the clinical team as Associate Meeting Secretary as Mr Sunil Bhudia takes over in the role of Deputy Meeting Secretary. Lastly, but by no means least, Mrs Nisha Bhudia, a Pharmacist NAHP member based at Harefield Hospital has joined as Associate NAHP Meetings Lead to support Ms Daisy Sandeman.

We are excited to organise another memorable annual meeting and we look forward to welcoming our members and guests in person to SCTS 2023 in Birmingham. ■

SCTS Executive Committee

President: Narain Moorjani

Honorary Secretary: Rana Sayeed

Honorary Treasurer: Amal Bose
Education Secretaries: Deborah Harrington, Elizabeth Belcher
Nursing & AHP Rep: Bhuvana Krishnamoorthy
Perfusion Reps: Chris Efthymiou, Mubarak Chaudhry
Elected Trustees: Enoch Akowuah, Aman Coonar, Betsy Evans, Andrew Parry, Manoj Purohit, Vipin Zamvar

Meeting Secretary: Cha Rajakaruna
Lay Representative: Sarah Murray
Trainee Reps.: Bassem Gadallah, Walid Mohamed
Communication Secretary: Sri Rathinam

Co-opted Members
Audit Co-Chair: Uday Trivedi
Research Co-Chairs: Eric Lim, Mahmoud Loubani
Innovation Co-Chair: Hunaid Vohra
Transplantation Co-Chair: Steven Tsui
Tutors: Michael Shackcloth, Mahmoud Loubani, Mubarak Chaudhry

Cardiothoracic Dean: Neil Roberts
SAC Chair: Tim Jones
Exam Board Chair: Sri Rathinam

SCTS Administration
Emma Piotrowski
Tilly Mitchell
Taet Chesterton
Maika Jimenez
Mara Banuta

Adult Cardiac Surgery

Co-Chair:
Enoch Akowuah

Executive Co-Chair:
Narain Moorjani

Appointed Members:
Hari Doshi
Georgios Krasopoulos
Giovanni Mariscalco

Audit Lead:
Uday Trivedi

Education Lead:
Deborah Harrington

NAHP Representative:
Lisa Carson
Kathryn Hewitt

Trainee Representative:
TBC

Co-opted Members:
Andrew Goodwin (NICOR)
Manoj Kuduvalli (UK Aortic Surgery Group)
Peter Braidley (NHS Commissioning)

Thoracic Surgery

Co-Chair:
Aman Coonar

Executive Co-Chair:
Rana Sayeed

Appointed Members:
Babu Naidu
Steve Woolley
Joel Dunning
David Healy
Leanne Ashrafian
Mark Jones
Syed Qadri
Malgorzata Kornaszewska
Nizar Asadi
Mathew Thomas
Doug West
Sri Rathinam

Audit Lead:
Kandadai Rammohan
Education Lead:
Elizabeth Belcher
Michael Shackcloth
NAHP Representative:
Xiaohui Liu
Trainee Representative:
Oliver Harrison
Jennifer Whitely

Co-opted Members:
Emma O'Dowd (BTS)
TBC (Commissioning)
Richard Steyn (Trauma)
Mark Steven (ACTA)

Congenital Cardiac Surgery

Co-Chair:
Andrew Parry

Executive Co-Chair:
Amal Bose

Unit Reps.:
Giuseppe Pelella
Andreas Hoschtitzky
Phil Botha
Tim Jones
Natasha Khan
Conal Austin
Mark Redmond
Branko Mimic
Martin Kostolny
Ramana Dhannapuneni
Mark Danton
Ed Peng
Massimo Caputo
Shafi Mussa
Fabrizio De Rita

Audit Lead:
Carin Van Doorn
Serban Stoica (Deputy)

Education Lead:
Attilio Lotto

NAHP Representative:
TBC

Trainee Representative:
Joseph George

Transplantation

Co-Chair:
Steven Tsui

Executive Co-Chair:
Rana Sayeed

Appointed Members.:
Marius Berman
Stephen Clark
Phil Curry
John Dunning
Aisling Kinsella
Jorge Mascaro
Rajamiyer Venkateswaran

Audit Lead:
Jorge Mascaro
Marius Berman

Website Lead:
Aisling Kinsella

Education Lead:
Espeed Khoshbin

NAHP Representative:
Emma Matthews
TBC

Trainee Representative:
Bassem Gadallah
Walid Mohamed

Audit

Co-Chair:
Uday Trivedi

Executive Co-Chair:
Rana Sayeed

Adult Cardiac Surgery Lead:
Uday Trivedi

Deputy Adult Cardiac Surgery Lead:
Dimitrios Pousios

Regional Deputy Adult Cardiac Surgery Leads:
Indu Deglurkar (Wales)
Zahid Mahmood (Scotland)
Alastair Graham (Northern Ireland)

Thoracic Surgery Lead:
Kandadai Rammohan

Deputy Thoracic Surgery Lead:
Nathan Burnside

Congenital Cardiac Surgery Lead: Carin Van Doorn

Deputy Congenital Cardiac Surgery Lead: Serban Stoica

NAHP Representative:
Hemangi Chavan
Nisha Bhudia
Zainab Khanbhai
Rosalie Magboo

Co-opted Members:
Andrew Goodwin (NICOR)

Education

Co-Chairs:
Deborah Harrington
Elizabeth Belcher

Executive Co-Chair:
Amal Bose

Surgical Tutors:
Michael Shackcloth
Mahmoud Loubani
Mubarak Chaudhry

Congenital Cardiac Surgery Lead: Attilio Lotto

Transplant Surgery Lead:
Espeed Khoshbin

NAHP Representative:
Bhuvana Krishnamoorthy

Trainee Representatives:
Bassem Gadallah
Walid Mohamed

Consultant Lead:
Prakash Punjabi
Shahzad Raja

Trust Appointed Doctors Leads:
Zahid Mahmood (Cardiac)
Kandadai Rammohan (Thoracic)

Student Lead:
Farah Bhatti
Karen Booth

Accreditation Lead:
Shafi Mussa

Communication Lead:
Vivek Srivastava

Research

Co-Chairs:
Eric Lim
Mahmoud Loubani
Executive Co-Chair:
Cha Rajakaruna

Adult Cardiac Surgery:
Enoch Akowuah
Gianluca Lucchese
Thoracic Surgery:
Babu Naidu
Congenital Cardiac Surgery:
Massimo Caputo
Nigel Drury
NAHP Representative:
Rosalie Magboo
Zainab Khanbhai
Julie Sanders
Hemangi Chavan
Nisha Bhudia

Trainee Representative:
TBC
Medical Student Leads:
Niraj Kumar
Gokul Raj Krishna
Co-opted:
Andrew Goodwin (NICOR)
Serban Stoica (Congenital Audit)
Gavin Murphy (Cardiothoracic SSL)
Luke Rogers (ASSL)
Ricky Vaja (ASSL)
Akshay Patel (ASSL)
Jacie Law (ASSL)
Ann Cheng (ASSL)
Brianda Ripoll (ASSL)

Professional Standards

Co-Chair
Sarah Murray

Executive Co-Chair
Andrew Parry
Bhuvaneswari Krishnamoorthy
Doug West

Meetings

Meeting Secretary:
Cha Rajakaruna
Executive Co-Chair
Sri Rathinam
Deputy Secretary:
Sunil Bhudia
Associate Secretary:
Carol Tan
NAHP Rep:
Daisy Sandeman
NAHP Rep Deputy:
Nisha Bhudia
Conference Organisers:
Tilly Mitchell/Maika Jimenez
Emma Piotrowski

Innovation

Co-Chair:
Hunaid Vohra

Executive Co-Chair:
Narain Moorjani

Appointed Members:
Ishtiaq Ahmed
Alex Cale
Massimo Caputo
Roberto Casula
Ranjit Deshpande
Joel Dunning
Hazem Fallouh
Rafael Guerrero
Shyam Kolvekar
Kelvin Lau
Nicolas Nikolaidis
Karen Redmond
Stephan Schueler

Trainee Representative:
Joshil Lodhia
Bassem Gadallah
Walid Mohamed

NAHP Representative:
Una Ahearn
Bhuvana Krishnamoorthy

Lay Representative:
Sarah Murray

Equality, Diversity & Inclusion

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Aswani Pillai
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Consultant Living Text Book Co-Lead:
Bilal Kirmani
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Trainee Rep (Senior):
Bassem Gadallah

Trainee Rep (Junior):
Walid Mohamed

Appointed Members
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SAC Chair Report

Timothy Jones, SAC Chair, Consultant Paediatric Cardiac Surgeon, Birmingham Children's Hospital

I feel privileged and excited to recently be appointed as Chair of the SAC in Cardiothoracic Surgery.

The SAC, or Speciality Advisory Committee, provides a key role in the development and improvement of postgraduate surgical training in the UK and Ireland. Working with the JSCT, ISCP, The Royal Colleges, GMC, SCTS and supporting the statutory educational bodies and Schools of Surgery, the SAC is responsible for curriculum development, national recruitment of trainees, quality assurance of training, trainees' progress and workforce issues, as well as providing input into the Certificate of Eligibility for Specialist Registration (CESR) process.

Training in surgery across all specialities is currently facing many changes and challenges. There are additional speciality specific challenges facing training in Cardiothoracic Surgery. With the introduction of the new curriculum in August 2021, we are all having to understand and develop new ways of training, assessment, and feedback in addition to adapting to a shortened curriculum. Whilst there are generic skills and knowledge required by all cardiothoracic surgeons, we also need to provide advanced speciality specific training necessary for a subsequent career in either thoracic, cardiac or congenital surgery. The delicate balance between matching recruitment with the number of training posts to consultant job opportunities has historically been difficult. The recent SCTS Toolkit highlighted the need for us to adopt new ways of working and this provides both challenges and opportunities for us all.

On top of all these changes, we are emerging from a global pandemic. Whilst the devastating impact of COVID continues to be experienced around the world, it has brought a specific set of problems to medical and surgical training and trainees across UK. We recognise training opportunities have been reduced, especially operative training and the pandemic has impacted moral across the workforce for a variety of reasons.

We don't have all the answers, but we have to move forward and build on opportunities and learn from past and present experiences.

The new curriculum is not optional. It is vital all trainees migrate to the new curriculum as soon as possible and start using the new assessment tools and ISCP pathways, which will be a requirement for all subsequent ARCPs. Trainees who were either ST7 or ST8 in August 2021 are the only people who have the option to remain on the old curriculum. In August 2023, all trainees will be migrated to the new curriculum.

"We have to engage with and evaluate the curriculum so we can refine and develop it. To this end, we are developing New Curriculum Training Packages for both trainees and trainers in cardiothoracic surgery."

We have to engage with and evaluate the curriculum so we can refine and develop it. To this end, we are developing New Curriculum Training Packages for both trainees and trainers in cardiothoracic surgery. These will shortly be available as well, as a series of webinars and face-to-face sessions including representatives from ISCP to help us understand the new assessment tools and curriculum requirements.

We are also carefully monitoring all trainees' progression following the introduction of the new curriculum. In addition, we are developing methods to demonstrate an individual trainee's progress with operative numbers, curriculum requirements, as well as engagement with the SCTS Educational Portfolio of training courses.

The appropriate use of the correct ARCP outcomes will ensure the needs of trainees requiring additional training opportunities or time is met. The Gold Guide has recently been updated and provides a clearer description of ARCP outcomes including the use of Outcome 10.

For those trainees considering sub speciality training, we are introducing placements in Congenital Cardiac Surgery and Transplantation for Phase 1 and 2 trainees that may either be accredited towards overall training time or not, if taken as an Out of Program Pause (OOPP). There are more details provided later in the Bulletin.

We are introducing post CCT sub speciality fellowships, accredited for training for those wishing to develop speciality expertise in areas such as Robotic Thoracic Surgery, Advanced Aortic Surgery and Mitral Surgery. These have come about due to the hard work of Elizabeth Belcher on behalf of the SAC.

The Quality Assurance of training is one of the key roles of the SAC and overseen by Shahzad Raja. Through the JCST and GMC trainee and trainer surveys, from our SAC Liaison members supporting Regional Training Committees, ARCP outcomes and from trainees' feedback via regional reporting we aim to get an overview of issues affecting trainees and training. The information is collated and feedback to the GMC. As trainees and trainers please ensure you complete the JCST and GMC annual surveys. Please also raise and feedback training concerns through either your regional Training Program Director, Head of School of Surgery, Liaison Member or

>>

directly to any member of the SAC. We can only respond to information provided and the recent low response rates for the GMC and JCST surveys have made meaningful interpretation in some regions difficult.

By the time you are reading this Bulletin the process of National Selection will be well underway. It is a complex process run by the SAC and overseen and under the regulation of the Medical Dental and Recruitment Services (MDRS). It requires a huge amount of work and we are extremely grateful to Steven Tsui and Ehab Bishay who have lead on the process, as well as to all the assessors for their time and commitment to the process. This year we are recruiting at ST1 run through training, which is now approved as a training pathway by the GMC. Previously it ran as a pilot project. We will also again be recruiting at ST4 for Thoracic Surgical Trainees. This is a pilot in its second year to meet the perceived need for thoracic surgeons to meet UK national targets. Recruitment at ST3 will no longer occur.

Finally, I would like to offer a big thank you to our outgoing Chair, Professor Marjan Jahangiri who has given a huge amount of time and energy to the SAC and training in Cardiothoracic Surgery across the UK and Ireland, whilst developing many of the projects detailed in this report. We will build on the work and accomplishments she has made over the last three years, and we are very grateful for her commitment and support.

"We will continue to work with the required statutory organisations as well as our trainee and trainer representatives and the SCTS to ensure a high standard of training in cardiothoracic surgery is maintained across the UK and Ireland."

We will continue to work with the required statutory organisations, as well as our trainee and trainer representatives and the SCTS to ensure a high standard of training in cardiothoracic surgery is maintained across the UK and Ireland. This is fundamental to delivering the highest quality care to our patients whilst developing and recognising excellence in our trainees and trainers. As an SAC, these objectives remain our priority.

If you require any further information, please do not hesitate to contact either me, Bassam Gadallah or Walid Mohamed who are our trainee representatives on the SAC or any other member of the SAC. ■

Audit Sub-Committee

Uday Trivedi, Consultant Cardiac Surgeon, Royal Sussex County Hospital

Taking over a role from anyone who has done a terrific job before is always daunting, and even more so when the individual concerned is Doug West. I would like to thank Doug for all his hard work and support with the audit sub-committee and for his personal to support for my work in the adult cardiac surgery audit.

The audit process has been difficult during the pandemic and all three domains (adult, congenital and thoracic) have been hit by the reductions in caseloads and increasing proportions of emergency and urgent work. Units have not reached their pre-pandemic levels of activity and currently the workload being done is on more complex and urgent cases, with surgery being undertaken much later in the disease process (both cardiac and thoracic). Trying to establish a 'new' normal will be a challenge as the case-mix has changed and the denominator is reduced.

At a national level the operational role of NICOR has changed. It is no longer under HQIP nor hosted by Barts. NICOR now sits under the broader banner of NHSE and will be hosted by Arden & Greater East Midlands CCG. The full implications of this are not known at the time of writing, but early indications are positive. An immediate effect has been that NICOR have negotiated with NHS Digital that all the cardiac audits will be exempt from the national data opt-out. This means that units do not need to check if their patients have opted out from having their data submitted. I know this will be a great relief to many audit leads and database managers.

The audit specialty leads remain the same with Carin Van Doorn and Serban Stocia overseeing the congenital audit, KS Rammohan with the thoracic, and I will continue with the adult cardiac. We are currently in the process of appointing deputies in thoracic and adult cardiac surgery.

Looking forward, there are a number of challenges facing all three audits for example: access to data, national benchmarking, and incorporating GIRFT into the audits. Hopefully, I will have more to say on these matters at a later date, but for now I look forward to steering a way through the challenges we face as we try and rebuild normality. ■

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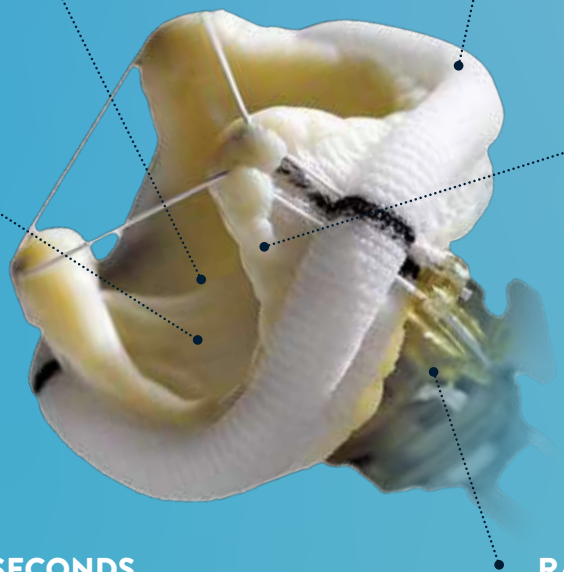

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SCTS Virtual National Research Meeting 2022 (Volume V)

Akshay Patel, NTN Trainee, Queen Elizabeth Hospital, Birmingham
Prof Eric Lim, Consultant Thoracic Surgeon and Professor of Thoracic Surgery, Royal Brompton Hospital and Imperial College London (NTRII Co-Chair)
Prof Mahmoud Loubani, Consultant Cardiothoracic Surgeon

This year, following the increased participation and successes of the former virtual national research meeting; the fifth instalment of the National Research Meeting took place on the 4th of November via the SCTS virtual platform with great enthusiasm from organisers, faculty, and delegates alike. This meeting was hosted with the unrelenting support of the Society of Cardiothoracic Surgery Executive Administration committee, the members of the SCTS Research Subcommittee, the Cardiothoracic Interdisciplinary Research Network (CIRN) and the wider membership of the society. The 2022 iteration saw a few changes to the dynamic and structure of the meeting. Firstly, a 4th prize category was introduced to recognise excellence in *Thoracic Surgical Oncology.* This prize was separate to the general thoracic surgical prize and was made through a sponsorship from AstraZeneca. In addition to the hugely successful plenary talks from years gone by, we introduced a research thinktank section which comprised four talks from world authorities in their field discussing the nuances of how to ask the right scientific question, how to structure a clinical trial and the logistics involved with trial set up and delivery. Lastly, in a meeting first ever, we introduced global participant voting on the quality of all the presented abstracts. Using the *menti.com* polling system, all delegates, faculty, and moderators were given the opportunity to mark each abstract out of five in a completely blinded fashion. The highest presentation score for each section was then combined with the individual shortlisting score and used to create an aggregate to determine the top ranking abstract and hence prize winners.

Over 110 participants registered, and 53 delegates attended the meeting. The meeting was introduced by Professor Mahmoud Loubani, with a clear emphasis on the need for good quality research activity to enable our specialty to go from strength to strength.

Each sub-specialty hosted truly inspirational plenary talks from world leading academics in their respective fields. In congenital surgery, Professor Igor Konstantinov from the Royal Children's Hospital in Melbourne provided an insight into the future of congenital heart surgery, with a focus on the exciting applications of xenotransplantation in neonates with life-threatening cardiac anomalies. Ms. Rosalie Renamagboo from Bart's Heart Centre and Ms. Nisha Bhudia from Harefield Hospital delivered a superb plenary talk in the Nursing and Allied Health Professional category. They have both taken up the mantle of SCTS NAHP research leads and are spear-heading a campaign to help drive NAHP research involvement in the speciality. They discussed the challenges, successes, and future plans encountered throughout their role thus far. Professor David Jones, the professor and chief of thoracic surgeon at the world-renowned Memorial Sloan Kettering Cancer Centre in New York, co-director of the lung cancer research unit and not to mention former secretary of the American Association for Thoracic Surgery, gave a truly compelling talk on how to balance life as a clinical academic. He is a real tour-de-force in the world of thoracic oncology and alongside giving lessons learnt through his own story, he gave useful advice on pathways to achieving academic scholarship whilst maintaining a thriving surgical practice. Lastly, but not least, we completed our series of plenary talks with an exciting talk from Professor Richard Whitlock of McMaster University in Ontario, Canada. Professor Whitlock is a cardiac surgeon with extensive experience in clinical trial design and delivery having led on the hugely impactful SIRS (steroids in cardiac surgery) and LAAOS III (Left Atrial Appendage Occlusion) Studies. He emphasised the importance of international collaboration in trial delivery and success. All talks were incredibly well received and sparked a high amount of intellectual discussion.

The research thinktank sessions were a "first" for the national research meeting agenda and featured four talks: 1. "How to formulate a fundable research question using the KetoLUNG case study" by Professor Gary Middleton. 2. "Why we do research" by Professor Gavin Murphy. 3. "How to work effectively within a trials unit for successful delivery" by Professor Chris Rogers. 4. "A case study of a successful clinical trial: VIOLET" delivered by Mr. Tim Batchelor. The sessions were hugely thought provoking with emphasis on performing good quality research which will make a difference to patients' lives and outcomes. This type of research takes time, money, enthusiasm and ultimately a network of like-minded individuals working collaboratively within a system that will nurture progress and deliver success.

The abstract presentation sessions were divided into a mixed congenital/transplant/NAHP, general thoracic and surgical oncology and general cardiac sessions. Each presentation was six minutes which was followed by four minutes of engaging debate and Q&A, hosted by the enthusiastic moderators: Mr. Serban Stoica, Mr. Edward Caruana, Ms. Leanne Ashrafian, Mr. Aman Coonar, Professor Mahmoud Loubani, Mr. Enoch Akowuah and Mr. Bil Kirmani. The final session for the day was delivered by Mr. Graham Cooper and Catherine Fowler of the Aortic Dissection Charitable Trust. They discussed the incredibly important work they are doing to raise awareness of this life-threatening condition but also showcased the funding opportunities available from this charity. They have already funded several exciting projects through a yearly call to funding, with the next

"Over 110 participants registered, and 53 delegates attended. The meeting was introduced by Professor Mahmoud Loubani, with a clear emphasis on the need for good quality research activity to enable our specialty to go from strength to strength."

opportunity opening mid-2023.

This meeting culminated in the award of four prizes. These were awarded to Dr. Ariadni Papadopoulou for "A Novel Morphometric Parameter for Biventricular Repair Candidate Selection in Congenital Left Ventricular Hypoplasia: Preliminary Study on 27 Specimens"; Alex Smith for "Robotic Assisted versus Video assisted Thoracoscopic Surgery for Thymectomy"; Mr. Akshay Patel (Surgical Oncology) for "A highly predictive autoantibody-based biomarker panel for prognosis in early-stage NSCLC with potential therapeutic implications"; and to Mr. Jeremy Chan for "Off Pump Coronary Artery Bypass Grafting in the United Kingdom".

This meeting would not have been possible without the unrelenting support and hard work of the organising executive research sub-committee; Professor Mahmoud Loubani, Professor Eric Lim, Mr. Edward Caruana, Mr. Alex Smith, Ms. Jacie Law, Dr. Usman Haroon, Ms. Emma Piotrowski, Ms. Taet Chesterton and Mr. Akshay Patel for their unyielding support throughout the process. The feedback received for this meeting has been excellent from both participants and faculty alike. In addition, special thanks to AstraZeneca for their sponsorship and assistance throughout.

This meeting has once again highlighted the impact of good-quality research, the importance of networking and collaborating between researchers and it provides an excellent platform for trainees and healthcare professionals to get involved in good quality research. We hope next year's meeting will just as if not more successful with an even greater turn-out and will serve to boost the reputation of the society, the profile of this meeting and attract speakers, whether it be delegates, plenaries or faculty, from far and wide. ■

Cardiothoracic Interdisciplinary Research Network (CIRN)

Luke Rogers, NTN Trainee, Bristol Royal Infirmary
Ricky Vaja, Cardiothoracic Registrar, Royal Brompton Hospital, London
Ann Cheng, NTN Trainee, Northern General Hospital, Sheffield
Brianda Ripoll, NTN Trainee, Castle Hill Hospital, Hull
Rosalie Magboo, Senior Sister, St Bartholomews Hospital, London

The Cardiothoracic Interdisciplinary Research Network, or CIRN, has never been more involved with the delivery of clinical trials in cardiothoracic surgery. The collaboratives own projects are coming to fruition (Target Wound Infection), as others are planned (THERMIC-4), and conceptualised (CardioPlastics – Sternal Reconstruction) whilst also facilitating the delivery and recruitment across the UK and Ireland of other national and international clinical trials (PROTECT MVr, PACeS, ROMA & TRICS IV).

This work only continues to grow and opportunities to get involved are ever expanding whether you have your own idea to pursue or simply want to get involved in some guideline changing work – now is the time!

This expansion necessitates that the CIRN's structure is formalised to ensure that the collaborative can continue to design, plan, recruit and deliver high quality, high impact clinical trials across the UK and Ireland relentlessly into the future. To accomplish this aim it is fundamental that the CIRN can coordinate and support nurses, allied health professionals, students and surgeons to recruit, appropriately informed, and consented, individuals to national and international clinical trials in every single non-private cardiothoracic surgery centre. To that end, we envisage teams of interested and enthusiastic multidisciplinary individuals working in unison with local institutional Research & Development departments in every centre with a locally appointed surgical, nursing and allied health professional lead that will directly integrate with the CIRN Coordinating Committee and ultimately, the SCTS Academic Research Committee. Keep your eyes peeled for the final ratification of the CIRN Terms of Reference in the not too distant future….. for now however, here is a an update on the CIRN's current projects:

Target Wound Infection

The NIHR program development grant looking into surgical site infection in adult cardiac surgery is well underway, with work progressing to time in the following work packages.

Work Package 1: accuracy of candidate predictors and existing prediction models for surgical site infection (SSI)

- In collaboration with Professor Whiting leading expert in systematic review methodology at University of Bristol and ROSSINI trial Chief Investigator Professor Pinkney
- 7,887 manuscripts reviewed
- 35 risk models identified

Work Package 2: mapping the patient pathway and implementation of interventions to minimise SSI

- Observations of 32 patients at four cardiac centres through their surgical care pathway
- Admission to postoperative ward and discharge

Work Package 3: identifying barriers and facilitators to SSI surveillance

- Responses from all 29 non-private cardiac surgery centres

We are hopeful that preliminary results will be disseminated in Birmingham at the SCTS Annual Conference in 2023. Planning continues towards the subsequent Program Grant for Applied Research (PGfAR) with the hope that this can be submitted in the coming summer. This will likely provide those working in trial sites for at least six months, when the study begins the opportunity to take up an NIHR Associate Principle Investigator scheme position.

> **"It is fundamental that the CIRN can coordinate and support nurses, allied health professionals, students and surgeons to recruit, appropriately informed, and consented, individuals to national and international clinical trials in every single non-private cardiothoracic surgery centre."**

THERMIC-4

THERMIC-4 will be a CIRN led, multicentre, feasibility randomised controlled trial (RCT)

to evaluate northermic versus hypothermic cardiopulmonary bypass in adult cardiac surgery. Work is well underway in protocol development, and we are aiming for the first patient to be recruited to trial in early 2023. CIRN members will be responsible for both the local delivery of the trial along with consultant surgeons willing to randomize patients at every non-private cardiothoracic surgery site in the UK and Ireland. This will involve the local CIRN lead being responsible for identifying eligible patients, approaching them to discuss the trial preoperatively and going through the consent process with them, if in agreement to be involved. Following this, orchestration of randomisation and data collection through the NICOR dataset and patient quality of life surveys will need to be maintained. If you and your centre would be interested in participating or would like any more information, please contact CIRN at CIRNetwork@outlook.com using the subject heading – **THERMIC-4**.

CardioPlastics – Sternal Reconstruction

Following our work on SSI's the CIRN has been approached by the Plastic Surgery colleagues including the associate Surgical Specialty Lead (aSSL) and the Reconstructive Surgery Trials Network (RSTN) to ultimately develop national guidelines on reconstructive surgery in the cardiothoracic surgery population. This work is very much in the conception stage with discussions only recently commencing between the CIRN and our Plastic Surgery colleagues although we anticipate that an early first step will be a national survey of practice to identify the preferences that exist, how, when, where and, to some extent, why they do from both perspectives. This work is likely to give those who haven't worked with the CIRN before an excellent opportunity to get involved! If you would like to get involved with this project when the finalised please get in touch with us at **CIRNetwork@outlook.com** using the subject heading – **CARDIOPLASTICS**.

Student Appointment

Gokul Krishna and Niraj Kumar were both elected to the SCTS Academic & Research Committee as student ambassadors for the SCTS working with the CIRN after a hotly contested shortlisting and interview process that was of an exceptionally high standard! Condolences to those that were not successful this time around – the quality of applications was fierce. There will still be an opportunity to get involved however as Gokul and Niraj are hoping to galvanise all enthusiastic and motivated peers to develop a national student project of their own with the guidance of the CIRN for mentorship. For more information, and their email addresses through which you can log your interest with them, check out their short introduction in this Bulletin.

If you're interested in getting involved with the CIRN, follow-us on Twitter @ CIRNetwork and drop an email to **CIRNetwork@outlook.com**, with your name, place of work and duration if a rotational.

We look forward to hearing from you! ■

Student SCTS Academic & Research Committee Representatives Cardiothoracic Interdisciplinary Research Network (CIRN)

Gokul Raj Krishna, Medical Student, Wythenshawe Hospital
Niraj Kumar, Medical Student, UCL
Ricky Vaja, Cardiothoracic Registrar, Royal Brompton Hospital, London
Luke Rogers, NTN Trainee, Bristol Royal Infirmary
Prof Mahmoud Loubani, Consultant Cardiothoracic Surgeon

Hello! We are the newly elected student representatives of the SCTS Academic & Research Committee. We took on this role so that we could work with the SCTS and with our partners in Cardiothoracic and Surgical organisations and societies across the UK to raise the awareness, and interest in cardiothoracic research!

We hope we can develop exciting opportunities for students interested in cardiothoracic surgery, surgery generally, and surgical research to come together; help make a difference, whilst building and developing positive relationships and learning the vital skills necessary to succeed in this profession. Both Niraj and I share a deep passion for improving research output amongst future cardiothoracic surgeons, and we aim to develop pre-existing research networks and integrate opportunities, and awareness for students and student societies all across the UK and Ireland. We anticipate forming a national research body primarily for medical students and young trainees, representing every university under the guidance and mentorship of the Cardiothoracic Interdisciplinary Network (CIRN) and SCTS.

Currently, we are working on developing a collection of project ideas and proposals in order to establish a nationwide research project that would a positive impact on current practice and patient care. We also envisage supplementing this with other exciting opportunities including student-led studies, research skills development, and the chance to learn more about the latest SCTS and global innovations.

Most importantly, we want to hear from you, medical students aspiring to be the cardiothoracic and academic surgeons of the future, as to how we can help you make an impact!

Feel free to contact us with any of your suggestions, queries or interests:

Gokul Raj Krishna
gokul.rajkrishna@student.manchester.ac.uk

Niraj Kumar
niraj.kumar.18@ucl.ac.uk

We look forward to hearing back from you. ■

SCTS Education Report

Debbie Harrington, SCTS Co-Education Secretary,
Consultant Cardiac Surgeon, Liverpool Heart & Chest Hospital

Elizabeth Belcher, SCTS Co-Education Secretary,
Consultant Cardiac Surgeon, Oxford University Hospitals NHS Foundation Trust

Since our last report for the Bulletin, we have several changes to our sub-committee to report. We would like to express our immense gratitude to Carol Tan for her years of hard work as part of the Education team, as both Thoracic Tutor and Education Secretary, as she now moves on to the Meetings team. In her place as Education Secretary and subcommittee co-chair we welcome Elizabeth Belcher, who moves from Thoracic Tutor. In addition, after a very competitive process, we have just appointed Mike Shackcloth, Consultant Thoracic Surgeon from Liverpool to succeed Elizabeth as Thoracic Surgical Tutor. We also welcome our Treasurer Amal Bose to the Education Team as our Executive Co-Chair, and look forward to working with him in the future. We are sad to see our longstanding Administrator Emma Piotrowski moving on from her role in Education and are hugely grateful for her dedication and hard work over the years. We look forward to continuing to collaborate with her in her new role at SCTS. We are delighted to welcome Mara Banuta as our new Education Administrator and look forward to working with her as we move forwards

We are grateful to our subcommittee members, Course Directors and Faculty, in all our education streams for their ongoing efforts to provide education for our specialty. We appreciate that this remains a challenge in the current climate for multiple reasons both logistic and financial.

Industrial partnerships

SCTS Education would like to thank our industrial partners for their generosity and support in these times of austerity. We would like to thank Ethicon, Medtronic (cardiac and thoracic), Medistim, Terumo Aortic, BD Medical, Corza Medical, Edwards, Corcym, and Zimmer Biomet and Veriton/Serb for their sponsorship and look forward to continuing to develop new partnerships in the future.

"We are grateful to our subcommittee members, Course Directors and Faculty, in all our education streams for their ongoing efforts to provide education for our specialty. We appreciate that this remains a challenge in the current climate for multiple reasons both logistic and financial."

Fellowships

In our last update we announced a new collaboration with Heart Research UK and can report that applications for these Fellowships have now closed. We will be announcing the successful applicants shortly.

We are also delighted to announce another new Fellowship collaboration with the Aortic Centre Trust. We will be giving more details of this travelling Fellowship and the application process in due course.

Consultant Education

Shahzad Raja and Prakash Punjabi continue to lead the Consultant Leadership Academy series, which has received excellent feedback so far. The new series 'What makes a good Consultant Surgeon', led by Professor Andrew George, will be advertised shortly.

NTN portfolio

The Surgical Tutor's report by George Asimakopoulos and Mike Shackcloth gives more detail on our successful course catch up programme post pandemic, which we can report we have now recently completed. The course portfolio has now been realigned with the new curriculum, although we do understand that realistically it will take several years to convert the programme from eight years to seven years. We plan to remain as flexible as possible with trainees around this and in particular timing of course attendance in the final two years of training. We do ask that all trainees update us with both their contact details and their current year of training, including exam status, so that we can ensure they are invited to the correct course at the appropriate time.

TAD Education

In line with the SCTS strategy of increasing equality, we aim to continue to improve access to education for our Trust Appointed Doctors. Zahid Mahmood and Kandadai Rammohan have been leading this with the CESR Application course which took place at Ashorne Hill on 16th November 2022. We aim to make this an annual course and would encourage TADs to attend this at an early stage in their training in order to be

able to fulfil the requirements for CESR completion in good time. The mentorship programme for Trust Appointed Doctors also continues to go from strength to strength. Going forward we will continue to offer the pre-exam revision & viva course (ST6) and the Leadership and Professionalism Courses (ST7.2) to eligible Trust Appointed Doctors as well as NTNS. There is also a Cardiothoracic Surgery update and wetlab for Trust Appointed Doctors of any level, at Ashorne Hill on 10th -11th January 2023. We continue to encourage the uptake of SCTS membership of Trust Appointed colleagues in order to allow increasing numbers of participants to access our course portfolio. In due course we hope to announce further courses which will be open to all trainees, irrespective of NTN or TAD status.

Congenital portfolio

The first SCTS Education dedicated congenital wetlab course ran on 9th -10th June at Ashorne Hill. This course was extremely well received with excellent feedback and we thank Attilio Lotto for his perseverance and dedication in establishing a fantastic addition to the SCTS Education portfolio. A further course is planned in 2023, details to follow soon.

NAHP Education

We are pleased to support Bhuvana Krishnamoorthy who continues to drive the NAHP curriculum forward with a new series of face to face events, including the first face to face SCP course taking place at Ashorne Hill on Friday 3rd February 2023.

Foundation Doctor Academy

We have been delighted to support this new initiative run by Hanad Ahmed comprising a weekly series of online teaching sessions on a range of topics across the specialty and aimed at recently qualified doctors aiming to pursue a career in cardiothoracic surgery.

Medical Student Education

The medical student education stream continues to flourish under the guidance of Karen Booth and Farah Bhatti. This includes a regular online teaching programme as well as the Student Engagement Day, this year in Hull, which took place on Saturday 19th November 2022.

As always, we continue to be impressed by the enthusiasm and dedication of colleagues in all streams of work. If you would like to contribute to SCTS Education either with ideas or as Faculty please do not hesitate to get in touch.

Finally, we would again like to reiterate our thanks to our administration team Emma Piotrowski, Taet Chesterton and Mara Banuta without whom SCTS Education would not exist. Please do let them know if your contact details change so that we can update our records accordingly and you are invited to the appropriate events. (**Education@scts.org**)

We wish everyone a healthy and happy 2023 and look forward to seeing you at SCTS Education events over the next few months. ■

SCTS Education Tutors' Report

Michael Shackcloth, SCTS Thoracic Tutor,
Consultant Thoracic Surgeon, Liverpool Heart & Chest Hospital

George Asimakopoulos, SCTS Cardiac Tutor,
Consultant Cardiac Surgeon, Royal Brompton Hospital, London

The NTN portfolio of courses is now running as planned after the disruption of the last two years with each course being delivered annually. We are grateful to all faculty and course directors for their hard work in preparing and delivering the courses.

In June we ran the ST3B/Phase 1: ST3.1 Operative Cardiothoracic Surgery Course. In September we ran a bespoke catch-up course in Hamburg at ST5 level for those trainees who had missed the ST3B course during the pandemic. The aim was to tailor the course to the level of each trainee and their requirements, as they had been variably affected by the reduced training opportunities during the pandemic. This 'Flex to the Next' approach is one we plan to continue. This will enable trainees to maximise the opportunities offered in Hamburg, and for trainees to attend Hamburg knowing their level of training will be used as a springboard to move from this level to the next. Most recently the ST6A/B/Phase 2: ST5 Subspecialty Practical Course postponed from February 2022, was held in Hamburg. The return of our Hamburg courses has been welcomed by all.

The ST4/Phase 2: ST4 Core Thoracic and Core Cardiac Surgery Courses and the ST3A/Phase 1: ST2.2 Introduction to Specialty Training in Cardiothoracic Surgery Course were all well received when they ran at Ashorne Hill. The ST2/Phase 1: ST2.1 Essential Skills Course was held in Nottingham for ST2 trainees and those planning National Selection application. This course will adapt to the changes in National Selection with a new focus on ST1 and ST4 Thoracic Themed applicants. December saw Ashorne Hill host the Introduction to Cardiothoracic Surgery Course and the ST8B/Phase 3: ST7.2 Leadership and Professionalism Course, which is open to TAD applications as well as NTNs. Courses planned for 2023 are summarised in the table.

The ST1 cardiothoracic trainees have received their Ethicon SuturEd Curriculum Access training packs. E-modules of suturing techniques and tissue management coupled with physical training materials and surgical tools are designed to assist early years competence in suturing. Informal feedback has welcomed this comprehensive program.

We would like to welcome Mara Banuta as our new SCTS Education Administrator. Emma Piotrowski in her role of Education Administrator has been at the heart of the SCTS Education team for over four years and we extend our sincere thanks for her endless enthusiasm and hard work over this time. We wish her all the best in her new role as SCTS Administrator and Conference Organiser.

We continue to urge each trainee to contact SCTS Education (education@scts.org) to ensure we have your correct contact details, including email address, telephone number and up-to-date level of training. This will enable us to invite you to the courses aligned to your stage of training. Please let us know if you think you should have been invited to a course, and do respond to any emails received as soon as possible, to assist in our course planning. We have released almost all of the 2023 course dates so that study leave can be booked at the earliest opportunity. The TPDs have also been informed of the course dates to support trainee attendance. The feedback we receive from attendees confirms these courses to be of high quality and educational relevance. We would urge you to attend when invited and look forward to welcoming you onto your next SCTS NTN course. ■

2023 Course Programme	Location	Date
ST3.2 Phase 1: Non–Operative Technical Skills for Surgeons (NOTSS)	Bristol Simulation Centre	19th – 20th January 2023
ST6 Phase 3: Revision & Viva Course for FRCS CTh (ST7A)	Ashorne Hill	27th Feb – 2nd March
ST7.1 Phase 3: Cardiothoracic Pre–consultant Course Practical (ST8A)	J&J Institute, Hamburg	26th – 28th April
ST3.1 Phase 1: Operative Cardiothoracic Surgery Course (ST3B)	J&J Institute, Hamburg	8th – 9th June
ST4.2 Phase 2: Core Thoracic Surgery Course (ST4B)	Ashorne Hill	12th – 14th June
ST2.2 Phase 1: Introduction to Specialty Training Course (ST3A)	Ashorne Hill	10th – 12th July
ST2.1 Phase 1: Essential Skills in Cardiothoracic Surgery Course	Nottingham City Hospital	18th – 19th September
ST4.1 Phase 2: Core Cardiac Surgery Course (ST4A)	Ashorne Hill	20th – 22nd November
ST1 Phase 2: Introduction to Cardiothoracic Surgery Course	Ashorne Hill	1st December
ST7.2 Phase 3: Leadership and Professionalism Course (ST8B)	Ashorne Hill	4th – 5th December

Operative cardiothoracic surgery course: A course worth attending

Amer Harky, NTN Trainee, Liverpool Heart & Chest Hospital

The operative cardiothoracic surgery course, currently known as ST 3.1 course, that takes place every year at Johnson & Johnson Institute in Hamburg, Germany is one of the last face to face courses I attended prior to COVID. Since then, it's been mainly online teaching. I was therefore looking forward to the ST6 course.

This year's course was different from other years since the trainees were mixed cohort of two levels of experience, some of us were from 2020 cohort as the original course delayed due to COVID-19 pandemic. Despite having these two different groups of trainees, the course was well adapted to meet the needs of all trainees. The sessions were well prepared and separated cardiac and thoracic trainees.

Each day, the program consisted of several group discussions and lectures followed by live operating. On the cardiac side this involved aortic root replacement, mitral valve surgery and off pump coronary artery bypass grafting including mammary harvesting. The team at J&J Institute at Hamburg were well prepared and supportive throughout the course.

The day would start with morning briefing and plan for the day, the trainees would divide into two groups within their special interest of either cardiac or thoracic. Each group was led by relevant consultants and were directed to either seminar rooms or the wet-lab area in which a dedicated team were awaiting and helping each trainee during the operative parts.

The overall course has been a great experience and it has offered an excellent learning opportunity for the attendees at operative and knowledge level. Additionally, it also serves a good time whereby trainees across the country meet up and share their own experience and progress, including new learnings over the past year.

I highly recommend this course and it is a must to attend it; visiting J&J Institute and exploring their amazing facilities provides an incredible insight. ■

"Exploring the amazing facilities at J&J Institute provides an incredible insight."

Course reflection

Rhona Taberham, ST5 Nationally Appointed Surgical Trainee

It was worth the wait (after multiple cancellations due to the pandemic) to attend the J&J Institute in Hamburg for the ST5 level bespoke operative cardiothoracic course. Five thoracic trainees (including myself) were grouped together for the duration of the workshop. The interactive cardiac and thoracic lecture sessions, focusing on knowledge for the exam, alongside practical tips for operating were of the usual high quality. Following a respectful presentation from the head vet (which greatly reduced my reservations surrounding operating on live animals), we were shown into the theatres. This was the best operative experience I have had on any course. The procedures were exceptionally similar to those in humans. The live nature meant that our technique had to be up to the same standard as it would be at work to keep the pig alive until the end of the session. Personally, I gained confidence in VATS diaphragm repair, arterial sleeve resections and performed a (less successful) sleeve pneumonectomy. I would jump at any opportunity to go on the course again. ■

Ashorne Hill Conference Centre: SCTS Strategic partner

Carol Tan, Past SCTS Education Secretary

SCTS Education marches into the 10th year and has achieved phenomenal success. Supported by grants from industry partners, our portfolio of courses is offered free to SCTS members. For the first few years of the programme, logistical support for NTN courses was offered by our industry partner (Ethicon).

When SCTS Education fully took on the administrative role for all courses from Ethicon in 2017, I had just been appointed SCTS Thoracic Tutor. We were faced with the mammoth task of all logistical arrangements to ensure the programme could continue within a reduced level of financial support from strategic partners. By word of mouth, we were introduced to Ashorne Hill as a potential location for many of SCTS Education's offerings.

With its central location in Warwickshire, range of meeting spaces from a large seminar room for lectures and wet-labs to smaller syndicate rooms for breakout sessions, and full-board facilities, this became the perfect location for many of our courses. It meant that faculty and delegates could be engaged in learning as well as networking for the whole duration of the course without having to move between different sites.

SCTS Education has run several courses at Ashorne Hill since 2018 and these have gradually extended beyond the NTN portfolio to other streams for TADs and subspecialty courses. During the COVID-19 pandemic when there was much disruption to the programme, we were faced with repeated unpredictable course cancellations, and the team at Ashorne Hill were enormously supportive of SCTS Education, allowing us to re-book courses without penalty despite being inundated with other requests as restrictions eased.

The SCTS Education team visited Ashorne Hill to review the facilities and discuss partnership proposals for future meetings. We are grateful for the continued hospitality and look forward to working with the team at Ashorne Hill for the educational meetings. ■

Thoracic Surgery report

Aman Coonar, Co-Chair, SCTS Thoracic Surgery sub-committee, Consultant Thoracic Surgeon, Royal Papworth Hospital, Cambridge

Rana Sayeed, Co-Chair, SCTS Thoracic Surgery sub-committee, Consultant Cardiac Surgeon, John Radcliffe Hospital, Oxford

Firstly, massive thanks to our demitting committee members for their major contributions: Simon Kendall (co-chair), Ian Hunt, Juliet King, Babu Naidu, Richard Steyn, and Steve Wooley. We have broadened the sub-committee membership to include representatives from all five SCTS nations, mixed practice surgeons, and include other stakeholders from the British Thoracic Society, the ESTS, and advisory groups on lung cancer. We welcome our new members who are Nizar Asadi (ESTS representative), Elizabeth Belcher (SCTS Education Secretary), David Healy (Eire), Mark Jones (Northern Ireland), Malgorzata Kornaszewska (Wales) & Mathew Thomas (Scotland).

ENGAGEMENT

Our focus has been on engagement to develop service standards and systems to help our members deliver high-quality services. We achieve that by regular virtual meetings and ad hoc WhatsApp chats.

LVR

Our progress on improving LVR services continues. SCTS LVR standards were published in March 2022. At the end of 2022, 11 of 38 thoracic units have established MDTs and treat LVR cases with valves and surgery. The LVR Working Group has produced an MDT proforma which is under consultation to drive the standardisation of data collection. We have written to all CEOs of thoracic surgery units to let them know we will be monitoring their progress!

LUNG CANCER UPDATES – SCREENING, SMALL NODULES & SEGMENTECTOMY

Lung cancer screening was commissioned in England in July 2022 (**https://view-health-screening-recommendations.service.gov.uk/lung-cancer/**).

This is a long sought-after milestone and will lead to an increased lung cancer workload both with respect to case volumes and types of lesions. We predict a 30% increase in workload over the next five years.

We expect to see an increase in the detection of smaller nodules requiring localisation. Further expertise and resources are likely to be required in nodule localisation, navigation, possibly robotics, and rapid pathological assessment.

There is a move towards segmental resection rather than lobectomy because of the potential for better outcomes with respect to the preservation of lung tissue and patient survival.

AKI AS A PERFORMANCE METRIC

The SCTS 'Multi Centre Evaluation of Renal Impairment in Thoracic Surgery' project was published in BMJ Open in September (**https://pubmed.ncbi.nlm.nih.gov/36167391/**).

Seventeen thoracic surgery units collaborated to enrol more than 15,000 patients to the study. Data were collected by SCTS Student members.

The study showed significant inter-unit variation in post op AKI rates and confirmed that AKI could be used as a performance metric to drive quality improvement.

THORACIC SURGERY SURVEYS

We have developed three related short surveys of thoracic surgery trainees, consultants, and surgical units and will incorporate the insights gained into a new set of thoracic surgery standards to support the development of the speciality and reduce regional variation. The surveys have been set up to be repeated with the addition of new fields as required to allow the monitoring to trends in the specialty.

We are pleased that 100% of units replied to the unit level survey. We hope that this will have been published on the SCTS website by the end of the year.

TRAINEES & TRAINING *(refer to their report)*

ST4 thoracic-themed training is now into its second cycle and most deaneries have submitted bids for ST4 thoracic trainees. There are ongoing discussions about cross-deanery/consortium bids which will be important to provide broader, more comprehensive training programmes.

The trainee network has 81 members providing support and updates through social media and maintaining a programme of engaging talks to educate and bring trainees together.

The trainees have organised several well-received webinars which are now available on YouTube, on the SCTS Thoracic Surgery Trainee channel (**https://youtube.com/channel/UCaMsXMb3EG2vEpkvRk6TsZw**).

THORACIC FORUM

After the successful restart in Wales in 2022 by Ira Goldsmith and Malgorzata Kornaszewska, the next meeting will be in Belfast hosted by Nial McGonigle in April (28-29 April 2023 TBC). This will follow the BTOG meeting and provide an opportunity to network with chest physicians and oncologists.

PECTUS

We have continued to push for the re-commissioning of pectus surgery in England. The Pectus Working Group is led by Simon Kendall and Joel Dunning and seeks to challenge the current unequal situation in which pectus surgery is not routinely commissioned in England but is available in the devolved nations of the UK and in Eire.

We are supporting a patient-led Best Practice for Pectus Day in February 2023 at the Royal College of Surgeons to raise awareness of this condition and the need for effective treatment to be available. ■

Communications Report

Sri Rathinam, Communication Secretary,
Consultant Thoracic Surgeon, Glenfield Hospital, Leicester

The Communications committee continues to oversee all aspects of communication of the organisation, interacting with the various co-chairs of the committees of SCTS and disseminating the information. We are making slow progress with our strategy and now have a wider team with representation across all membership and strands of the specialty.

Bulletin, Newsletter and From the Chest

The Bulletin thrives under the leadership of Indu Deglurkar and for the first time we are raising the revenue ourselves through a collaborative approach. The Industry and partners are offered sponsorship packages or stand alone options to support the annual meeting, education, research, as well as advertising in the Bulletin.

The feedback from streamlining our communication from multiple emails to a weekly E-Newsletter has been very positive. (Figure 2)

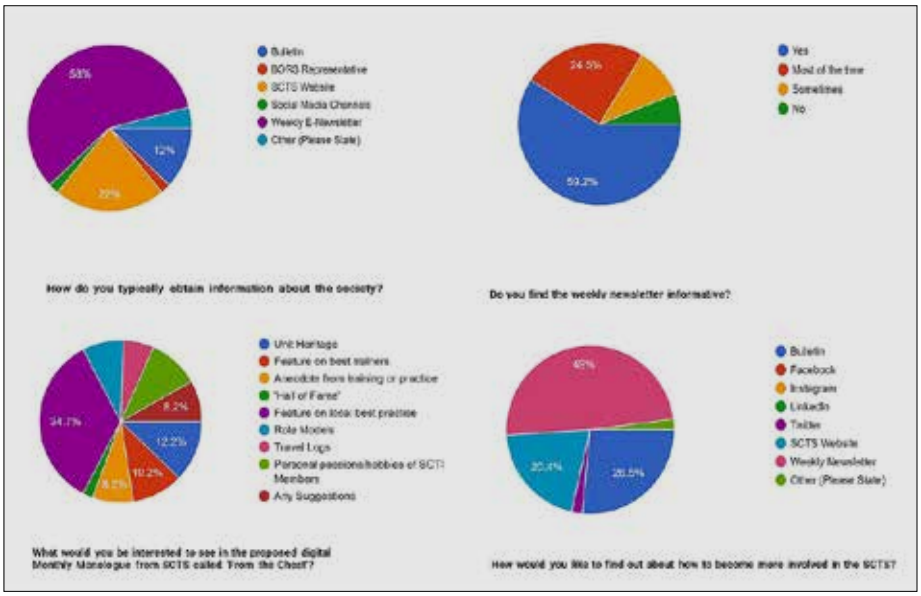
We invite articles for the first edition of "From the Chest". We would value pictures and articles focusing on Christmas Spirit. The E-monograph will include the President's monthly update, highlight profiles of office bearers, showcase "what is good" from the units, work life balance articles, unit history and competition with tickets to the Annual Dinner on Monday 21st March at the Burlington Hotel.

Publication of Abstracts in the JTCS

We have partnered with the Journal of Cardiothoracic Surgery to publish the abstracts from the 2022 SCTS annual meeting and a process in place for 2023. The vision is to bring out supplements to have topical SCTS University lectures in the form of Perspective in Cardiothoracic Surgery.

Webinars of Constitution Review

SCTS its composition and executive have evolved and changed over the last two decades (Figure 3). We are going through a period of growth and expansion with our membership and with that in mind, there will be webinars and communications regarding the various propositions, as well as focused newsletter communications. The final discussion will be in the annual general body meeting, we urge colleagues to contribute to this decision making, if you are not attending please contract the honorary secretary, **rana.sayeed@ouh.nhs.uk**, with your opinion and vote by proxy.



BORS and Unit Engagement

The BORS meeting was a grand success where we bid farewell to Isabelle Ferner, our Society Administrator, and Simon Kendall, who after two decades of service for the SCTS, demitted office as President. It was poignant that Mr Jules Dussek and Mr Robert Lamb, the President and treasurer who appointed Isabelle, graced us with their presence and shared the story of her appointment. The meeting discussed various focused aspects of the SCTS with vibrant exchange of thoughts covering the Constitution review, BHU survey, Report of the Mental Health wellbeing working group and various sub-committee reports.

The **BORS report**, which we seek from the unit representative, has been modified and will be offered as an on line form. So that Unit representatives can modify and send back to Emma for a biannual report, which will be shared in the BORS meeting and AGM.

The **Unit engagements** commence from January to gain insight from various units and to address the challenges as to how SCTS can help and support them.

Website

The website is constantly evolving and there are plans to have key clinical guidelines in the website, and in addition highlighting each sub committee's work in the public domain. We will also have toolkits and supportive information on MHW and BHU. We will also have a focused section on reducing sternal wound infections with best practice and tips further to a benevolent donation.

A picture says a 1000 words

SCTS executive, elected trustees and officers have expanded and the office bearers now represent a more diverse workforce and membership.

The changes over the last two decades are in keeping with the SCTS agenda of inclusivity and widening participation.

SCTS Education – Journey over a decade book

SCTS Education is one of the crown jewels of SCTS and it has achieved a lot in the last decade. We are the only specialty to offer a portfolio of curriculum aligned courses to our trainees and now our trust appointed doctors anywhere in the world. The fellowships and various educational offering are one of a kind. We will produce a book to showcase all these achievements, as well as a Toolkit to highlight the process map for others to emulate our progress in simulated learning.

Public Information and Engagement

The various clinical committees are working towards having patient stories as well as information on our website to guide our patients and public.

SCTS is hosting a public event on Pectus surgery in partnership with RCSEng, RCSEd, BAPRAS, BOA (and hopefully RCPCH) in the Royal College of Surgeons of England on the 9th February to raise awareness about this challenging deformity which has physical, physiological and psychological impact on children and young people. SCTS is also in the process of creating a Best Practice guideline for the condition lead by Joel Dunning, Ian Hunt and Simon Kendall.

Collaboration with other Organisations

SCTS was a key contributor to the Stake holder meeting organised by the **Royal College of Surgeons of England** to explore **Collaborative International Strategy** to explore and support training, education and professional standards in the international arena.

SCTS also supports the **UK Health Alliance and the Sustainable surgery partnership** and the recent launch of the **Green surgery checklist** supported by the Royal College of Surgeons of Edinburgh, Royal College of Surgeons of England and The Royal College of Physicians and Surgeons of Glasgow.

SCTS has signed a Memorandum of Understanding with the **European Society of Thoracic Surgeons** to work in close collaboration.

SCTS offered a joint meeting with the **ACTAAC** on professionalism and collaborative working in November 2022, which had to be postponed due to the train strikes. This will now be held in November 2023 at the Royal Society for Medicine.

SCTS members supported the **Quadripartite JSF exams** held by the Royal College of Surgeons of Edinburgh in partnership with the University of Hong Kong, National University of Singapore and Malaysian Association of Cardiothoracic Surgeons. **MACTS** is keen to collaborate with SCTS in replicating an educational portfolio similar to SCTS portfolio.

Colleagues from SCTS have contributed and supported the **Egyptian Society for Cardiothoracic Surgery** Meeting in November 2022 virtually, with plans to collaborate on next year's meeting.

As always, we welcome any suggestions and feedback on how we can improve communication from SCTS to the members, patients and the public. ■

Intercollegiate Specialty Board in Cardiothoracic Surgery Updates

Sri Rathinam, Chair, Intercollegiate Specialty Board in Cardiothoracic Surgery

The new format Joint Committee of Intercollegiate Examinations (JCIE) Intercollegiate Specialty Examination was conducted in Sheffield in October 2022 with Norman Briffa as the host examiner. The JCIE thanks Norman Briffa for the selection of volunteers, instruments and a keen group of medical student volunteers who made the exam a great success.

The exam had the return of volunteers and recognised increased sub-specialisation within the new curriculum, with alternative sub-specialty oral exams in either Cardiac or Thoracic Surgery.

Any change will always cause anxiety and added to the fact, we had a train strike on our standard setting day posed challenges. We thank our JCIE secretariat team and the group of professional examiners who made this exam a success with all the changes within the new format examination.

Changes to Candidates not in Training

For all new entrants to UK/Ireland Examinations from October 2023 there are changes to the eligibility criteria to be able to appear for the Intercollegiate Specialty Fellowship Examinations:

Full details can be found on the applications page of the JCIE website (**www.jcie.org.uk/content/content.aspx?ID=22**)

Joint Surgical Colleges Fellowship Examination (JCSFE)

The Section 2 diet of the examination was held in Malta from November 29th to 1st December 2022. Further dates and details can be found on the JSCFE website (**www.jscfe.co.uk**)

Examiner Recruitment

We thank colleagues who have applied to become examiners; we have admitted seven colleagues into the Panel of Examiners. The JCIE is always grateful for your commitment and expertise in setting the standards and examining the future surgeons in the specialty.

We request consultants who have completed five years with an interest in training and assessment to consider applying to become an examiner for the JCIE.

Details can be found at the JCIE website at (**www.jcie.org.uk/content/content.aspx?ID=23**)

We welcome newly appointed consultants to contribute to the MCQ question writing group, details can be found at (**www.jcie.org.uk/content/content.aspx?ID=41**)

Intercollegiate Specialty Board

We welcome, as a Board Member, Ms Juliet King in the role of Section 2 Leader of the Panel of Question Writers. Ms King has also been appointed as Thoracic lead for the Panel. Mr Mark Jones has been appointed as the Cardiac lead for the Panel.

We congratulate and welcome Mr Tim Jones, the new SAC Chair.

We congratulate Mr Mike Lewis who has been appointed as the Chair of the JCIE. He is the third Cardiothoracic surgeon to hold the post after Prof David Richens and Mr Tim Graham.

The next diet of the Section 2 examination will be held in Liverpool in May 2023. ■

Nursing and Allied Health Professional update

Prof Bhuvaneswari Krishnamoorthy, SCTS Nursing and AHP Chair, Reader in Health and Social Care and Postdoctoral NIHR Research Fellow, University Hospital of South Manchester NHS Foundation Trust

It is important for all of us to take a deep breath and leave things which are stressful for our physical and mental health. I cannot believe how last year has vanished in to thin air so quickly.

As NAHP SCTS Chair, it is heart breaking to hear about higher incidence of stress, work-related sickness, mental health issues and whistle blowing tragedies among our NAHPs across the UK. Mental health and wellbeing should be the main focus in our work and home life. Please do not take your work stress to home and vice versa. Remember, kind words and a smile can make your colleagues feel valued, in return, their compassion can help your wellbeing as well.

Education report

It has been a very productive year and we conducted four full day courses online. However, due to immense work pressure in the NHS, the advanced physiotherapy, advanced lung transplant and aortic root symposium courses had to be cancelled over the past few months. The courses will be reinstated from January 2023, with the face-to-face at the Ashorne Hill, Leamington Spa venue. We are looking for a passionate lead to organise virtual monthly webinars/ online forum discussions for nurses and allied health professionals. In addition, please express your interest by contacting me on **b.bibleraaj@salford.ac.uk** with your full CV and the reasons as to why are interested in this post.

EACTS presentation

We had two abstracts accepted as oral presentations at the EACTS Conference 2022, in Milan. One of the project works was carried out by our SCTS Mental Health and Wellbeing committee (Prof. B Krishnamoorthy, Ms. Sarah Murray, Mr. Aman Coonar and Mr. Sridhar Rathinam). The second survey was to explore the barriers and challenges of nurses accessing research on their day-to-day work. Both oral presentations were delivered by Mr. Rick Air, Surgical care practitioner from Manchester Foundation Trust. We would like to thank him for his hard work and for taking the time out to present at EACTS. All the data was collected and analysed by two volunteers Mr. A Rathinam and Mr. S Raaj.

Postdoctoral researchers NIHR Colloquium

Our first joint NIHR, RCSEdinburgh and SCTS nurses' colloquium took place on 30th September 2022. The event was attended by the NHS managers and postdoctoral nurses across Great Britain. It was aimed to bring together like-minded researchers to discuss how to develop Clinical Academic (CA) career pathway in the NHS. Great discussions took place regarding the issues of contract and funding between the organisations. NHS England Director of Nursing Prof. Ruth May, NIHR Director of Nursing Prof. Ruth Endacott and many others explained the next five-year strategic plan for CA pathway. Importantly, it was mentioned that embedding research as part of nurse's weekly job plan from band 5 onwards, will eliminate any barriers to research.

To access, please click this link: **https://www.england.nhs.uk/wp-content/uploads/2021/11/B0880-cno-for-englands-strategic-plan-fo-research.pdf**

Venous/Arterial Ultrasound course

Our first competency-based ultrasound certified course was held in April 2022. It was attended by 15 delegates and 13 completed their clinical competency portfolio successfully. This course is suitable for surgical care practitioners, vascular scientists, vascular surgical fellows and nurses. The second course will be held in November 2022 at the Royal College of Surgeons Edinburgh, Birmingham office. It is a hands-on practical skills course with a series of competencies to complete between three to six months.

International membership

The importance of international collaboration is vital for our NAHPs to share the practice across the continents. It brings a wealth of knowledge and skills to be transferred among the practitioners. The international membership fee is £15 per annum and they are able be attend the meetings and access education at a reduced rate. However, they will not be able to apply for any executive or lead positions within the NAHP committee. Please promote this to your colleagues and friends from another continent to apply for this new offer. All details can be found at SCTS membership page **https://scts.org/membership/member_benefits.aspx**

Inspirational Star of the year 2022

We received many nominations for our first series this year. We have selected top five nominees, they are Miss. Amy Millichope (ACP from Birmingham), Miss. Xiaohui Liu (ACP from Southampton), Mrs. Jayne Sharman (ACP from Glenfield), Mrs. Nisha Bhudia (Pharmacist from Harefield, London) and Mrs. Daisy Sandeman (ACP, Edinburgh). The interviews will be released monthly. Well done to all the nominees and congratulations to the winners.

What is new for the next 6 months?

- Wellbeing interactive discussion forum.
- Intercontinental NAHPs symposium.
- Face-to-face educational courses return.
- Case studies to create awareness about bullying and harassment.
- Nominate your team for the NAHP team award 2023. Advert is out now. ■

NAHP Sub-committee report

Cardiac report:

Miss. Kathryn Hewitt

As NAHP Cardiac Lead, I have been working closely with the Cardiac Committee to focus on raising MDT standards nationally through innovation with good governance, and working as a multidisciplinary team to overcome the significant impact of COVID19. As NAHP Cardiac Lead, my current aim is to focus on improving access to national teaching and meetings to empower nurses and AHPs to invest in and stay within the specialty. Thus, increasing numbers of operations and improving wait times for our patients.

Over the next year we will see our first face-to-face Advanced Cardiac Surgery Course for NAHPs since the pandemic, looking at skills used daily by Advanced Practitioners within Cardiac Surgery. All NAHPs of all professions and grades are welcome to come along to learn new skills, practice old skills and network with other like-minded practitioners. Full details to follow.

Perfusionist report:

Mrs. Lisa Carson

The last six months have seen an increase in awareness in the perfusion community of the NAHP subsection SCTS. Stemming from the interest generated by the SCTS perfusion team of the year award and the dissemination of information on educational courses to this group of professionals. It is hoped that SCTS membership and involvement of this group of staff will continue to increase. As the perfusion representative, I have been involved in a number of educational webinars to SCTS medical students FY1/FY2s in addition to providing lectures on CPB/ECMO as part of the SCTS INSINC series. This has been a great opportunity to build an understanding of the perfusion role within the cardiac surgery pathway.

Finally, we are at the final stages of planning of the 'Introduction to V-A ECMO' study day planned for the 17th November, at Glenfield Hospital Leicester. An exciting event designed to introduce the subject to cardiothoracic professionals working in non-ECMO centres. Lectures and simulation sessions will be delivered by both cardiac surgical and ECMO teams to comprehensively cover the subject area.

Physiotherapist report: Mrs. Zoe Barrett-Brown

As the Physiotherapy lead, I have been working hard on a Physiotherapy course looking at advanced practice. As like many professions, Physiotherapists are taking the leap into extended scope practitioner (ESP) and advanced clinical practitioner (ACP) roles, but in fields that are already have these roles established (like MSK, critical care etc). During the next year I would like to work on bench marking services across the CT centres and look at ways we can develop the Physiotherapy role with Cardiothoracic Surgery. We have also been working on getting the Thoracic surgery Physiotherapy network off the grounds, which has been a huge success.

Research and audit report:

Miss. Rosalie Renamagboo and team

The virtual Nursing and Allied Health Professionals (NAHP) Core Research Skills Course has been rescheduled to 19th November 2022, due to Her Majesty Queen Elizabeth II's funeral in September. We are very grateful to all the speakers and moderators for their understanding and flexibility for the new chosen date. The application for the NAHP mentorship programme, which was launched in the last University Research and Audit Day in Belfast, will open in December 2022. Details for joining will be available on the SCTS website. Please watch this space.

We have been supporting the Cardiothoracic Interdisciplinary Research Network (CIRN) in their work on TARGET Wound Infection, a National Institute for Health and Care Research (NIHR)-funded study which aims to develop new care pathways for the personalised prevention of wound infection following heart surgery based on measurement of individual risk. Please visit **https://scts.org/professionals/research/cirn.aspx** for further information.

The national quality improvement (QI) project on prevention of atrial fibrillation after cardiac surgery (AFACS) is progressing well. Twenty cardiac centres have signed up to participate and so far, eight centres have completed their baseline audits and are currently implementing the AF care bundle project. It is not too late to join. If you are interested, please contact Ms Nisha Bhudia (**n.bhudia@nhs.net**) and Ms Hema Chavan (**h.chavan@rbht.nhs.uk**), SCTS NAHP audit leads.

Finally, we are also supporting a national service evaluation entitled: PROTECT Mitral Valve Repair UK Enhanced Feasibility Survey led by Prof Enoch Akowuah, which started on 1st November 2022 up to 28th February 2023. This survey aims to generate feasibility data of UK practice in mitral valve repair to provide evidence to a potential randomised controlled trial. This was a great opportunity for NAHPs in cardiac surgery to get involved in another national audit.

Thoracic report:

Miss. Xiaohui Liu

The darkness falls earlier, the weather is cold and wet, tiredness after a long day work. What can you do to make you feel better? Whatever it is, do it for yourself and family. You are as much as an important person like other health care professionals in the National Health Service and you deserve a complete rest.

As the Thoracic Surgery lead, I have been continuously seeking opportunities to develop some new services to benefit Thoracic colleagues throughout the UK. One of the developments is to develop a network from different Thoracic centres in the country, which will allow us to anticipate the support our Thoracic colleagues need, and we will provide our support accordingly.

We have been working hard to collect more interesting materials and talks for our next Thoracic Skills course 2023, which will be in January/February next year. Date and venue to be confirmed soon. We will advertise it as soon as the above is confirmed. We are looking forward to seeing many of our Thoracic colleagues at the course. ■

SCTS INSINC Committee update:
"INpiring Students INto Cardiothoracic surgery"

Josh Brown (pictured right), **SCTS INSINC Communication Lead, Medical Student, Queens University, Belfast**
Amerikos Argyriou, SCTS INSINC Student Lead, Foundation Doctor, University Hospitals Bristol and Weston
Karen Booth, Student Education Lead, Consultant Cardiac Surgeon, Freeman Hospital, Newcastle
Prof Farah Bhatti, Student Education Lead, Consultant Cardiothoracic Surgeon, Morriston Hospital, Swansea

The SCTS Student committee INSINC have been busy following the successful end to their first year of tenure, culminating in the immense Pat Magee research and INSINC Masterclass as part of the SCTS Annual Meeting in Belfast. The committee was established with a clear vision to inspire students to pursue careers in cardiothoracic surgery, by improving accessibility and increasing awareness of the specialty. With a new academic year well under way it was finally time for the implementation of the committee's latest projects including the 2022 Student Engagement Day that, after a hard-fought application process, hosted by Hull York Medical School Cardiothoracic Surgery Society on 19th November. We anticipated a fantastic jam-packed day of key note lectures and a huge focus on offering highly immersive practical based skills sessions and wetlabs following the success of our previous student days and the feedback of student's wanting more hands on experience.

Since starting SCTS INSINC in 2021, we have grown student membership from 85 to 272 student members throughout the UK and Ireland. We have broadened our education and access schemes specifically through;

1. The INSINC education series

The committee began the INSINC Education series where virtual lectures are being delivered to medical students and junior doctors with content mirroring the training curriculum for cardiothoracic surgery and applications to medical school finals examinations and in-depth foundation knowledge to aide medical students on cardiothoracic attachments. These run on Tuesday evenings at 19.30 and details can be found on the events section of the SCTS website as well as on all our social media platforms.

2. INSINC INSIGHT

A major focus of the INSINC vision is to extend our efforts to sixth form students applying to medical school and we are proud to announce the soon to be piloted INSINC INSIGHT widening participation scheme. Three pilot centres will be offering work experience placements to sixth form students with official SCTS designed programmes providing engrossing exposure to the world of cardiothoracic surgery and medicine as a career path. Students will have access to SCTS education materials ahead of the placement including an online lecture series and individualised 'one note pack' to ensure they can maximise their learning. Students will be hand selected from local schools who meet WP criteria and we hope to inspire students who would not have previously wanted to enter medicine.

3. National Cardiothoracic Audit

We are hoping to launch our cardiothoracic audit scheme in the coming months where students can participate from around the UK to get involved in national quality improvement projects.

Our events are always broadcast via our social media platforms, so keep your eyes peeled for the latest announcements on twitter and Instagram: @SCTSINSINC and Facebook: SCTS Students insinc. ■

Leaving a Lasting Legacy: Inspiring your next generation of cardiothoracic surgeons

Javeria Tariq, SCTS INSINC Committee Member, Final Year Medical Student, Leeds School of Medicine

Amerikos Argyriou, SCTS INSINC Student Lead, Foundation Doctor, University Hospitals Bristol and Weston

Medical students can often find themselves blending into the background amidst hierarchical culture, thereby struggling to gain adequate exposure required to truly appreciate a surgical specialty. But our experiences define the very people we become, and it takes a single positive interaction to dictate future hopes, plans and dreams. In this article, we describe first-hand our career-defining experiences in the hope that we demonstrate the capacity to inspire your junior colleagues. The juniors of today may well become the surgeons of tomorrow and what's better they may even credit you for some of their successes.

We write as two committee members of the INSINC (INspiring Students IN Cardiothoracic surgery) SCTS sub-committee, lead by Prof Bhatti and Ms Booth. Within our roles, we have come across some exceptional opportunities in particular through hosting the national Student Engagement Day in Leeds in 2021. We would like to inspire other consultant members of SCTS by describing what we have experienced.

SCTS INSINC committee at the 2021 Student Engagement Day with our lead Prof Bhatti in Leeds

SCTS INSINC committee at the 2022 Annual General Meeting in Belfast with our lead Ms Booth

Mr Alessandro Brunelli is a Consultant Thoracic Surgeon and distinguished academic who became president of ESTS last year. My first experience of thoracic disease beyond textbooks was in theatre with Mr Brunelli. He recognised me as an equal, taking every opportunity to teach. The spirit in which he taught was beyond sharing specialist knowledge, but imparting wisdom gathered through more years than I have lived. I was struck by his humility and way with patients. Surgeons are commonly perceived as desensitised, but he presented to me the dual role he takes everyday as a thoracic surgeon and humanitarian. I aspire to mirror his methods in my own practice. Therefore, attending the ESTS meeting was a career-defining experience as we fell more deeply in love with the specialty. So much so that even considering the challenges prevalent in the specialty, we could not think of a better way to spend our working lives.

We were extremely fortunate to have been offered the opportunity to attend the ESTS 2022 Conference as honorary guests of the 30th President: Mr Brunelli. He offered us two free Presidential tickets to ESTS, not only as attendees but with networking opportunities at their trainee meeting and Presidential Reception. We attended an exciting and informative three-day conference that took place in the Netherlands and observed first-hand the camaraderie and spirit of collaboration that embodies thoracic surgery. We attended expert sessions led by pioneers in the field, attended research presentation sessions to hear about the latest breakthroughs in clinical trials, and networked with the ever-growing trainee community attending the conference. It was an incredibly rewarding experience and our personal highlights from the conference included attending the trainee evening and meeting surgeons from all over Europe, as well as listening to the ESTS Presidential address by Mr Brunelli, focusing on the concept of "Sawubona" and using patient testimonials that Javeria had helped to collect. One final memory that left a profound mark on us both, was having coffee and chatting with not one, but two past ESTS presidents. They shared sincere, personal tales of their professional journeys, and of once being medical students such as ourselves, with no plan or aspirations beyond getting through their next set of exams. This conference provided us with an


Amerikos (right) with President Dr Brunelli (centre) and Javeria (left) at the ESTS 30th annual meeting in The Hague, Netherlands


Amerikos applying practical skills at an aortic wetlab at the Royal College of Surgeons HQ, London

arsenal of new knowledge and academic skills but even more so, it revealed the thriving and welcoming community of surgeons that exist in a field that we would otherwise be largely oblivious to. This experience was incredibly positive, as we both realized this large family of European thoracic surgeons would love to have us join them; with the only admission requirements being a passion for this job and the spirit of teamwork.

Ms Carin Van Doorn is Lead Consultant Congenital Cardiac Surgeon in Leeds. She generously invited us to an Aortic Valve Masterclass in London. The day commenced with a series of short talks regarding the management options for aortic valve disease, followed by deep discussions on the different valvular interventions available alongside their outcomes. The afternoon consisted of a wet lab where we performed ascending aortic replacements with our student lead, Ms Booth. Although we did not mirror the level of proficiency of some of the registrars, the exercise was priceless in that it allowed us to gain invaluable personal tips and tricks from distinguished faculty members. A personal highlight of mine was being in the company of Ms Van Doorn as she discussed her experiences with the Ross procedure.


Ms Van Doorn delivering her keynote lecture at the 2021 Student Engagement Conference

My first meeting with Ms Van Doorn was at the 2021 Student Conference I directed, where she attended to give us her keynote talk. She delivered a humbling lecture titled "Standing on the Shoulders of Giants: Role Models That Continue to Inspire Me" which foreshadowed her role in my career, alongside her unwavering passion to educate. I remember sharing my first ever time in theatre witnessing a Norwood Procedure. She proceeded to invite me into her department, it seemed her only currency of value seemed to be passion. I took every subsequent opportunity to shadow her. Compared to other placements I have undertaken this stood out, with the standout element being Ms Van Doorn herself. I accumulated a wealth of knowledge under her wing that I could attribute to the fact that she was a tremendously talented surgeon that exuded control. I vividly recall a case where her field was obscured due to right atrial return despite cannulating the SVC. With complete composure, she explained to me the concept of a persistent left SVC. Another time the anatomy once inside the chest was not as anticipated and armed with only blood-stained DeBakey's she drew out the intricacies of her plan on drapes to explain why she was amending the standard approach. Ms Van Doorn has this way of ingeniously crafting opportunities to teach from any situation, a hallmark of a great educator. Trusting in my ability, she allocated responsibility to me during her cases so that I felt valued, which in turn allowed me to flourish as I felt comfortable translating criticism into personal development. My most treasured memory was scrubbing for a case with an all-female congenital surgical team. As a true mentor should, she instilled confidence that empowered me to outgrow my limiting factors after all, as a young female budding surgeon, it is difficult to aspire to be what you cannot see.

We would both like to take this opportunity to express our heartfelt thanks to Dr Alessandro Brunelli and Ms Van Doorn for their invaluable support and investment in our careers. ■

"It was an incredibly rewarding experience and our personal highlights included attending the trainee evening and meeting surgeons from all over Europe."

SCTS Foundation Doctor Academy

Hanad Ahmed, SCTS Foundation Doctor Representative, Cambridge University Hospitals
Abdul Badran, Immediate Past Chair of the SCTS Trainee Committee, Southampton General Hospital

Foundation doctors have long been wedged between medical school and specialty training. As a result, education programmes and courses have tended to be aimed at medical students, or specialty trainees with invitations extended to foundation doctors.

With the UK Foundation Programme being the bridge between medical school and specialty training in cardiothoracic surgery, it is important to specifically acknowledge this group of doctors and provide educational courses that enhance not only insight into the specialty, but also deal with the ward-based challenges faced by FY1 and FY2 doctors managing cardiothoracic disease.

It is for this reason that the SCTS Trainee Committee established the Foundation Doctor Academy, encompassing a national teaching programme supported by SCTS Education. The programme was piloted over the last few years and in its latest iteration has delivered weekly teaching, attended by foundation doctors in the UK, Ireland and beyond.

The sessions have been completely free for both members and non-members, taking place virtually on Monday evenings to allow plenty of opportunity for foundation doctors to attend around on-calls and other commitments. The focus has been on the recognition and management of common cardiac and thoracic pathology, as well as interactive case-based discussion to enhance understanding.

The 2022 programme, created and led by our current SCTS Foundation Doctor Representative, Dr Hanad Ahmed, has attracted a regular national attendance and received feedback expressing a need for further foundation doctor targeted teaching.

While we plan for the 2023 programme, we would like to highlight that this year's course would not have been possible without the endless commitment and collaborative work of the SCTS Education administrators Emma Piotrowski and Taet Chesterton. The commitment and support provided by both Emma and Taet have allowed things to run seamlessly and acknowledging their crucial contribution is as important as the success of the programme itself.

We also thank all delegates for their attendance and engagement with the programme and express our gratitude to all the speakers who have given up their time and tuned in across time zones to provide high quality teaching to the next generation of cardiothoracic surgeons. Your time and efforts have been invested in the future of our specialty, a gift that will keep on giving.

The following table highlights the 2022 concluded programme, formally acknowledging all speakers. ■

Session 1	Coronary Heart Disease	Mr Yassir Iqbal ST8 Cardiothoracic SpR Queen Elizabeth Hospital, Birmingham
Session 2	Lung Cancer	Ms Annemarie Brunswicker ST6 Cardiothoracic SpR University Hospitals Manchester
Session 3	Aortic Valve Disease	Mr Kamran Baig Consultant Cardiac Surgeon St Thomas' Hospital, London
Session 4	Surgical Management of COPD	Mr Aiman Alzetani Consultant Thoracic Surgeon University Hospital Southampton
Session 5	Cyanotic Congenital Heart Disease	Professor David Barron Consultant Congenital Cardiac Surgeon Hospital for Sick Children, Toronto, Canada
Session 6	Mitral Valve Disease	Mr Dimitrios Pousios Consultant Cardiac Surgeon University Hospital Southampton
Session 7	Acyanotic Congenital Heart Disease	Ms Carin Van Doorn Consultant Congenital Cardiac Surgeon Leeds Teaching Hospitals
Session 8	Chest Radiographs & SHO On-Call Scenarios	Miss Hannah Jesani ST3 Cardiothoracic SpR New Cross Hospital, Wolverhampton
Session 9	Empyema	Mr Alessandro P. Tamburrini Consultant Thoracic Surgeon University Hospital Southampton
Session 10	Haemothorax and Pneumothorax	Mr Sridhar Rathinam Consultant Thoracic Surgeon University Hospitals of Leicester
Session 11	Infective Endocarditis	Mr Mustafa Zakkar Associate Professor of Cardiac Surgery University Hospitals of Leicester
Session 12	Chest Trauma	Mr John G. Edwards Consultant Thoracic Surgeon Sheffield Teaching Hospitals
Session 13	Cardiopulmonary Bypass	Ms Lisa Carson-Price Senior Clinical Perfusionist University Hospitals of Leicester
Session 14	Cardiac Tamponade	Mr Yassir Iqbal ST8 Cardiothoracic SpR. Queen Elizabeth Hospital, Birmingham
Session 15	Pre-operative Assessment in Cardiac Surgery	Mr Luke J. Rogers ST7 Cardiothoracic SpR Southwest Deanery
Session 16	Pre-operative Assessment in Thoracic Surgery	Mr Mohammad Hawari Consultant Thoracic Surgeon Nottingham University Hospitals
Session 17	Cardiac Anaesthesia & Intensive Care	Dr Tom Pierce Consultant Cardiac Anaesthetist & Intensivist University Hospital Southampton
Session 18	Acute Aortic Syndrome	Mr Giovanni Mariscalco Consultant Cardiac Surgeon University Hospitals of Leicester
Session 19	Cardiothoracic Transplantation & Mechanical Circulatory Support	Mr Stephen Large Consultant Cardiac & Transplant Surgeon Royal Papworth Hospital, Cambridge
Session 20	Post-operative Management in Cardiac Surgery	Mr Jason Ali Consultant Cardiac & Transplant Surgeon Royal Papworth Hospital, Cambridge
Session 21	Post-operative Management in Thoracic Surgery	Mr Abdul Badran ST8 Cardiothoracic SpR University Hospital Southampton

If you are an ST7+ SpR, Consultant or Senior Clinical Fellow and would like to contribute to the 2023 programme please email NTCCTS@gmail.com

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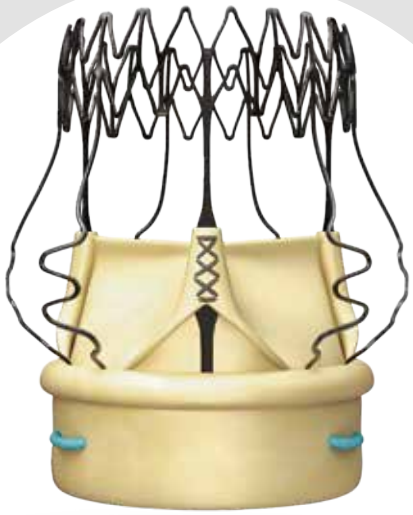

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REFERENCE

1. Lamberigts M. et al., *JTCVS (2022); doi: https://doi.org/10.1016/j.jtcvs.2022.09.053/py*

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Cardiothoracic training programmes in Australasia – closer than you think!

Abdul Badran, Immediate Past Chair of the SCTS Trainee Committee
Jason Trevis, Academic Foundation Doctor, James Cook University Hospital
Charles Jenkinson, RACS trainee chair

To continue the series in reviewing global training pathways, we take a look at the Australasian perspective. There are 55 different units that deliver cardiothoracic services in Australia and 5 in New Zealand. This serves a population of about 30 million and compares to the 52 units in the UK serving more than double.

The training in Australia and New Zealand is carried out through the binational Royal Australasian College of Surgeons (RACS) under contract, with a curriculum and Specialist Training Board appointed by the Australian and New Zealand Society of Cardiothoracic Surgeons. There are approximately forty trainee surgeons across both countries, who undertake a six year training program. Of the 55 units, 30 are designated training centres (25 in Australia and 5 in New Zealand).

The application is a competitive process after medical school, usually following a period of time working as an "unaccredited" registrar, where often significant training and experience is obtained prior to entering the formalized training scheme. The minimum requirements for selection include two surgical rotations (>10 weeks in duration) including one cardiothoracic placement. Work based assessments (DOPS) for chest drain insertion, saphenous vein harvest and radial artery harvest. In reality applicants will complete courses, undertake research, and present at conferences, whilst building up a network of professional referees to support their application. The selection criteria is based on a curriculum vitae, structured referee reports as well as an interview which accounts for 45% of the selection marks. Upon successful completion of all requirements (including supervisor evaluation reports, logbook, research, and three sets of both written and viva examinations), a Fellowship of the Royal Australasian College of Surgeons (FRACS) is bestowed. This is often followed by further Fellowship training, often (in the pre-COVID-19 era) undertaken overseas.

The actual training programme is six years in total with a mid training RACS cardiothoracic surgical science and principles examination that must be passed before the fourth year which consists of a written and oral format. Successful completion of the programme requires an achievement of minimum operative experience prescribed by the RACS. This includes indicative numbers of major cardiac and major thoracic cases that need to be completed as performed both independently or supervised. There is also a minimum number of cases where the trainee assists in completion.

The final RACS fellowship examination must be taken from the 5th year of training and is the exit examination with written and multiple oral components. It can only be sat when 75% of the minimum required operative experience has been achieved.

Training in Australia faces similar issues to programmes around the world. Access to operative training cases remains difficult for many, especially in units employing senior Fellows, who are already able to operate independently. The shift towards thoracoscopic and minimal access surgery, as well as catheter-based interventions, has further diluted primary operator opportunities for trainees. Also, being a binational training scheme spanning a geographically large region of the world, many trainees are required to move across state or national borders for training which has been particularly evident in the COVID-19 era where such travel has had massive implications on those with partners, children and family in other parts of Australia and New Zealand. There is a 5,364 km span between our most distant trainees (Perth, Western Australia to Hamilton, New Zealand). This is around 200 km off the distance from New York to London.

The requirments from the Australasian programme are actually remarkably similar to the UK training scheme with less time afforded in the new latter curriculum exiting at ST7. The vast geographical location and population densities are a particular challenge compared to the UK structure, but these also translate into logistical and infrastructure planning to facilitate healthcare delivery in general, as well as quality training regardless of geography. ■

Clinical
6 years of clinical rotations (undertaken at >=3 centers)
Satisfactory trainee evaluation at 6 monthly intervals
Satisfactory completion of DOPS assessments by staff surgeons
Completion of minimum procedural logbook cases
Completion of RACS skills courses and workshops
Academic
Publish 2 peer-reviewed manuscripts
Complete 10,000-word research thesis (or higher research degree)
Participation at annual Scientific meeting
Examination
Generic surgical sciences examination (before entry into training)
Clinical examination (years 1-2 of training)
Cardiothoracic surgical science and Principles examination (years 2-4 of training)
Fellowship examination (years 5-6 of training)

Table with requirements for completion of training

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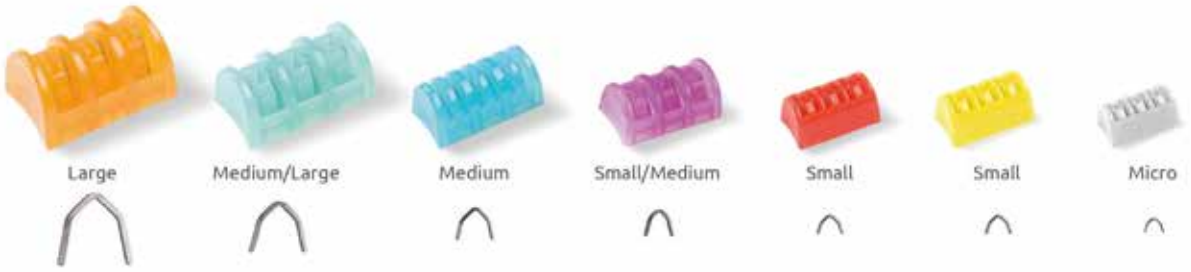

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Aortic Dissection Awareness Day UK 2022

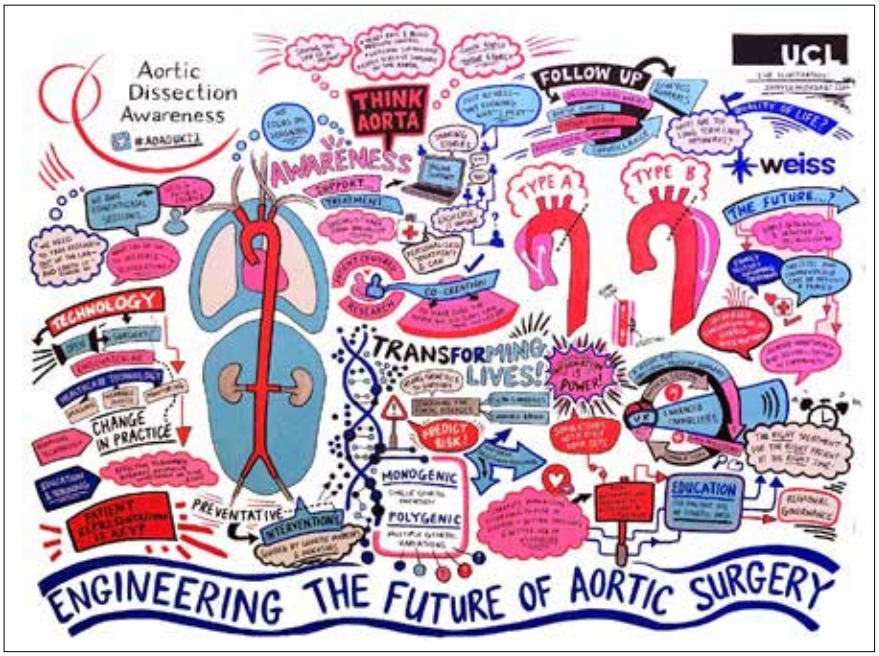
Christina Bannister, Nurse Case Manager, Southampton General Hospital

The 7th annual Aortic Dissection Awareness Day UK, rescheduled from 19th September to 31st October 2022 due to HM The Queen's funeral, was hosted by the University College London Welcome Institute for Interventional Surgical Sciences (WEISS-UCL) at BMA House in central London. The national patient charity Aortic Dissection Awareness UK & Ireland organised the event and invited SCTS member Prof. Aung Oo, Clinical Lead of the Complex Aortovascular Service at Barts Health NHS Trust, to deliver the keynote address and set out his vision for "The Future of Aortic Surgery". Many other SCTS members attended as invited guests of the national patient charity from specialist Aortic centres across the country. The theme of the 2022 event was "Engineering the Future of Aortic Surgery" in alignment with UCL's pioneering research programme.

A live visual artist, Jenny Leonard (**www.jennyleonardart.com**) created a stunning artwork in front of the audience during the day, summarising the presentations and discussions on "Engineering the Future of Aortic Surgery". After the event, the original 2.5m x 1m artwork was transported to UCL, where it now hangs as a reminder of AD Awareness Day and a reference for researchers in the field. Prof. Vanessa Diaz, Professor of Cardiovascular Engineering at UCL, said "It is such an honour for us to host AD Awareness Day UK and to be able to share our 10-year research programme and the work of our current PhD students on Aortic Dissection with a wider community". Five UCL PhD students presented posters about their Aortic research.

In his introduction, the Chair of the national patient charity, Mr. Gareth Owens, cited SCTS data showing a 29.1% increase in the number of patients undergoing surgery for Type A Aortic Dissection between 2015 and 2018. He welcomed this as the first solid evidence that increased awareness through campaigns like THINK AORTA is delivering a step-change in diagnosis and in the number of dissection patients undergoing and surviving surgery. In real terms, this means that around 200 more patients per year are surviving acute Aortic Dissection. This data only told half

Prof. Aung Oo at BMA House with the Chair & Vice-Chair of Aortic Dissection Awareness UK & Ireland Mr. Gareth Owens & Mrs. Haleema Saadia & the hosts of Aortic Dissection Awareness Day UK 2022, Prof. Vanessa Diaz & Prof. Stavroula Balabani from UCL.



A live visual artist at the event created this stunning artwork to summarise the proceedings of Aortic Dissection Awareness Day UK 2022 (credit: jennyleonardart.com).

Aortic Dissection Awareness Day UK is a unique event organised by patients, for patients and invited clinicians. All of the delegates in this photograph survived an acute Aortic Dissection.

the story, however. Patient Simon Jones gave a very personal account of how his life was saved when an A&E doctor diagnosed his acute Aortic Dissection after reading a THINK AORTA poster. Simon's message was simple and powerful: "THINK AORTA works".

AD survivor Anne Cotton gave an account of her amazing journey through three open Aortic surgeries at two different Aortic centres over seven years. She praised the work of SCTS members at Derriford Hospital and Mr. Jorge Mascaro and his team at the QEII in Birmingham, who together replaced her entire Aorta – from root to iliacs – in three challenging open procedures.

Mr. Owens also welcomed the work that has started in every Region, supported by SCTS, to implement the new NHS England acute Aortic Dissection toolkit. As the only patient member of the toolkit working group, he reiterated his vision of patients receiving "specialist care, by specialist surgeons, in a specialist centre, 100% of the time, in all regions" and said that this would reduce the "big five" risks of Aortic Dissection surgery: Mortality, Stroke, Paraplegia, Infection and Re-intervention.

It was inspiring to see Aortic Dissection survivors from centres all over the country attend the event in significant numbers with their families. Clinicians remarked on what a pleasure it was to attend an event which facilitated such excellent opportunities for networking with patients outside a clinical setting. This is a unique feature of Aortic Dissection Awareness Day UK.

A key aim of AD Awareness Day UK is to bring people together to focus on improving care for Aortic Dissection patients. Vascular surgery was represented by Prof. Rob Sayers from Leicester, Medical Advisor to the national patient charity, who chaired the second session of the morning. He introduced an excellent talk by another vascular surgeon, Mr. Seamus Harrison, on the topic of how Genomics will affect the future of Aortic surgery and lead us towards personalised medicine for these patients. This theme was picked up by international guest speaker Dr. Ben Youdelman, Director of Aortic Surgery at the Maimonides Medical Center in New York and Clinical Lead of the THINK AORTA US campaign. He spoke about the value of the THINK AORTA-THINK FAMILY concept in preventing Thoracic Aortic Disease and about new minimally-invasive techniques and technologies that will improve Aortic surgery in the future.

In the afternoon, delegates were split into mixed tables of patients, relatives, clinicians and engineers for some research co-design workshops, in a large and very successful engagement exercise. UCL and the patient charity had invested in professional facilitation skills training ahead of the event for a group of Aortic Dissection patients, each of whom facilitated the discussions at their workshop table. Delegates discussed the high-quality research being undertaken into CFD simulations of individual diseased aortas and their complex haemodynamics by engineers at UCL. The objectives of gathering broader clinical perspectives on the application of this research and ensuring that it is patient-centred were successfully achieved.

Aortic Dissection Awareness Day UK 2022 was generously sponsored by **Terumo Aortic**. Patients enjoyed seeing and handling some of the Dacron grafts used to repair their aortas, especially the Frozen Elephant Trunk, which featured in some of the presentations about the future of Aortic surgery.

At the end of the day, Dr. Bobby Agrawal, a Cardiac Imaging specialist from Cambridge, was welcomed to the stage, as Mr. Owens announced that the hosting of AD Awareness Day UK 2023 has been awarded to the Royal Papworth NHS Foundation Trust, in recognition of their excellent specialist Aortic service and leadership in the field. Next year this very special event will take place on **Tuesday 19th September** at the new **Royal Papworth Heart & Lung Research Institute**. Please save the date if you would like to join us!

Aortic Dissection Awareness UK & Ireland also plan to attend the SCTS Annual Meeting in Birmingham in March. They encourage all SCTS members to visit their stand, meet some patients and talk about their work. ■

Creating a National Network for Physiotherapist's working in Thoracic surgery in the UK & Ireland

Zoe Barrett-Brown, Team Lead Physiotherapist for Thoracic Surgery Royal Papworth Hospital
Michelle Gibb, Clinical Specialist Physiotherapist for Thoracic Surgery, Glenfield Hospital

Physiotherapists are integral members of the thoracic surgery MDT providing care from the pre-operative phase all the way to the post-operative and discharge of a patient's journey. We all know Enhanced Recovery After Surgery (ERAS) is becoming our bread & butter for all surgery now. Physiotherapists have a leading role in ERAS programmes; developing and delivering Prehabilitation, involvement in high-risk MDTs and pre-operative screening to delivering post-operative interventions facilitating airway clearance and early mobility including day 0/ several hours after surgery, returning to function and follow up and discharge planning just to name a few, with our role excitingly ever advancing.

We were put in touch with one another through a mutual colleague where we began to discuss our thoracic services and our roles within the MDT. We arranged to visit each other at our trusts to see first-hand the way each centre worked which really sparked a lot of ideas for the future. One of these being having a network for Physiotherapists who have specialised in working with thoracic surgery. Over the next few years at SCTS annual meetings, emails and the Covid-19 pandemic and multiple lockdowns and two maternity leaves, we discussed the thoracic network more and more. We have seen Physiotherapy networks be very successful within respiratory physiotherapy such as the Association of Chartered Physiotherapists in Respiratory Care (ACPRC) as well as smaller more niche networks such as the ECMO physiotherapy network, allowing for multi-centre and expert collaboration.

As a specialised Physiotherapist you have peers within other respiratory or surgical specialties with transferable knowledge and skills, but we felt it would be a huge benefit to have a network of peers who work in thoracic surgery. Our aim of the network was to learn and share practice from one another, each thoracic unit across the UK undertakes fantastic work and instead of re-inventing the wheel, the network would allow us to learn from one another but have the aim of standardising and enhancing practice across the UK within thoracic surgery. Also, to work on service developments, audits and research and a great sounding board to bounce ideas off one another.

We reached out to trusts across the UK with thoracic surgery departments and used the power of social media via Twitter to find physiotherapists who had specialised in thoracic surgery and wanted to join the network.

We currently have a Physiotherapy representation from 27 different trusts. The interest in the thoracic surgery physiotherapy network was incredible! After much co-ordinating and organising we had our first meeting! Our first meeting happened in October 2021. It was a fantastic turn out and after introductions we discussed the role of the physiotherapy network and agreed a virtual quarterly meeting would be our preferred option.

We created a central database for information sharing and the first order of business was team infrastructure for each thoracic team within the thoracic network. At this point it was clear to see that each trust was so different in levels of staffing, bed base covered, number of specialities covered with some teams purely thoracic surgery and others combined cardio-thoracic

surgery and ITU. We also observed a variety of settings that teams were involved in for example pre-op clinic to ward based only. It was inspiring to see so many like-minded peers so keen to share practice and really put physiotherapy on the map with all their hard work.

For the network to be successful engagement from everyone involved is key. We decided for the next years meetings we would have a topic and asked members to undertake a short informal presentation each meeting.

In April this year we met virtually, and our meeting topic was Prehabilitation. The meeting gave us all such food for thought and we had brilliant presentations from members of the network involved in different types of Prehabilitation all in different regions of the UK. Speakers included: Lindsay Charlesworth – Macmillan Advanced Therapist Practitioner at John Radcliff Hospital Oxygen University Hospital, Catherine Sandson, Physiotherapist at the Royal Marden NHS Foundation Trust, Tracey Jones, Highly Specialised Cardiothoracic Physiotherapist at Moriston Hospital in Swansea and Katie jones, Specialist Cardiothoracic Physiotherapist Prehabilitation Project Lead at the Golden Jubilee National Hospital. It was amazing to be able to see what other teams were doing and how they were working to prove success and maintaining services. Also, the difficulties such as the short window we have to provide prehab for our patients and how teams had or were trying to overcome barriers like these. It was also great to see so many new posts being developed and trialled and that the NHS and Cardiothoracic Trusts are getting behind Prehabilitation and Physiotherapy. I think we all agreed the meeting had us all jotting down ideas and was a great source of inspiration for service developments.

At our next meeting (November 17th) we will be looking at ERAS after Thoracic Surgery. And the following meeting in early 2023 is going to be discussing advancing physiotherapy roles within thoracic surgery and we can't wait for the discussion and services developments to come from it.

As physiotherapists we are always striving to improve the care and endeavour to provide the best for our patients whilst developing and highlighting the importance of our role and the work, we get to do alongside the brilliant thoracic MDT that we all work with. We hope that as a network we will be able to showcase some more of the brilliant work that goes on within physiotherapy and thoracic surgery across the UK at the SCTS annual and research meetings, hopefully you will see the physiotherapy representation grow in numbers and strength within the SCTS too.

Thank you to everyone who is already participating in the network and all the speakers without you our vision for this network would not succeed.

If you are one of the trusts, we have yet to have representation for please do join us! Our aim is to have a Physio rep from each CT centre in 2023! ■

Is there a role for Physician Associates in Cardiothoracic Surgery in Great Britain & Ireland?

Elizabeth Belcher, Department of Thoracic Surgery, Oxford University Hospitals NHS Foundation Trust, UK

Ramanjit Kaur, Departments of Cardiac and Thoracic Surgery, Oxford University Hospitals NHS Foundation Trust, UK

Rukshunda Ali, Departments of Cardiac and Thoracic Surgery, Oxford University Hospitals NHS Foundation Trust, UK

Rosalyn Rosas, Assistant Clinical Professor, School of Health Professions, University of Texas Health Science San Antonio, Texas, USA

The Physician Associate Lead of the SCTS Nursing and Allied Health Professional (NAHP) subcommittee remains vacant. Is there a role for Physician Associates in cardiothoracic surgery in Great Britain & Ireland?

The Physician Associate role was first developed in 1965, when Dr Eugene Stead of Duke University recognised that former military medics from the Vietnam War, with a wealth of experience in trauma and emergency medicine, might be part of the solution to a shortage of primary care physicians in the USA. Based on his experience of fast-tracking medical training of doctors in World War II and using a competency based medical curriculum, he utilised this educational model to develop a two-year training program. In 1967 four former Navy medical corpsmen, graduated as the first Physician Associates (initially known as Physician Assistants) from Duke University. Since 1975, the National Commission on Certification of Physician Associates (NCCPA) in the USA has certified over 185,000 Physician Associates. Surgical Subspecialty practice is the top certified Physician Associate practice area, and most are employed in the specialities of orthopaedics and cardiothoracic and vascular surgery.

Physician Associates have been practicing in the UK since 2002 and the first training scheme was established at St George's, London in the early 2000s. Since then, over 40 universities offer Physician Associate postgraduate training programs in Great Britain & Ireland with some, more recently, offering undergraduate courses.

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In Oxford we appointed Physician Associates to complement the role of our established Advanced Nurse Practitioners (ANPs) and Surgical Care Practitioners (SCPs). Oxford was the first cardiothoracic centre to appoint SCPs in the early 1990s and the Oxford Thoracic ANP has led the development of nurse led chest drain clinics and our CT follow-up program for lung cancer patients. As part of a 'Time to Educate' program, Oxford appointed first in Trust cardiothoracic Physician Associates in 2017. The aim was to support our Foundation Years doctors whilst facilitating our registrar level trainees to attend high quality training areas of theatre, MDTs, and new patient clinics. The decision to appoint Physician Associates rather than increase other Allied Health Professional (AHP) roles was taken to avoid depletion of our highly skilled ward, intensive care, and theatre staff and to bolster retention of staff. The average retention of Physician Associates in posts in the USA is nine years.

These appointments were based on a cost avoidance business case where daytime ward-based locum surgical doctors were replaced by this third branch of AHPs. Physician Associates were introduced onto the wards, pre-admission and outpatient clinics. We initially appointed a Physician Associate with ten years' experience in cardiothoracic surgery from the Cleveland Clinic, Ohio, together with a Physician Associate newly graduated from a UK program. Since these first appointments in cardiothoracic surgery, further Physician Associates are now embedded within the emergency department, urology, gynaecology and haematology departments in our Trust.

The addition of Physician Associates has provided ongoing high-quality clinical care for cardiothoracic patients whilst supporting our Foundation Years trainees during their short-term placements in our department. The presence of Physician Associates has increased the quality of training opportunities for our NTNs, by releasing registrar time previously spent supporting Foundation doctors on the ward. Whilst improvements in trainee surveys and Patient Performance Indicators are difficult to attribute to any one area of change, the appointment of Physician Associates has been, one factor associated with these improvements. Improvements in Oxford GMC trainee surveys where red flags have been transformed to positive outlier status, have been seen in the areas of workload, and overall satisfaction of trainees. Positive changes in these areas can be seen to commence in 2017 where the appointment of Physician Associates supported our newly developed Oxford based NTN program.

"Physician Associates have been practicing in the UK since 2002 and the first training scheme was established at St George's, London in the early 2000s. Since then, over 40 universities offer Physician Associate postgraduate training programs in Great Britain & Ireland with some, more recently, offering undergraduate courses."

Each cardiothoracic centre has embraced AHP roles in ways best suited to patient needs and local requirements. AHPs have the skills to deliver the highest quality care, as evidenced at the NAHP awards at the SCTS Annual Meeting in Belfast. Whilst Physician Associates may undertake similar roles to ANPs and SCPs, their training is in the medical model of diagnosis and management, and they are generally science graduates trained in the foundations of medicine and surgery.

The thoracic surgery department in Manchester has experience of Physician Associates on a rotational basis. Physician Associates commonly rotate through departments as they are required to revalidate by recertification examination every six years. In Oxford, we have found that the varied pathologies and comorbidities of cardiothoracic patients has facilitated our Physician Associates to recertify without departmental rotations.

Currently, Physician Associates register on a voluntary basis, with the Faculty of Physician Associates, administered by the Royal College of Physicians. Although Physician Associates are not yet able to prescribe, since this is predicated on the requirement for mandatory registration with a regulatory body, it is expected that the Department for Health and Social Care will complete the legislation to facilitate this in the summer of 2023. The GMC were selected as the regulatory body for Physician Associates. Once mandatory body registration is enacted the role of Physician Associate can expand to fulfil its true potential to include prescribing, building on their graduate training in pharmacology and their ability to request ionising radiation. At present, the Physician Associate Managed Voluntary Register (PAMVR) held by the Faculty of Physician Associates at the Royal College of Physicians, allows employers to confirm an applicant is a fully qualified and approved Physician Associate.

Physician Associates in Great Britain & Ireland are established in primary care and hospital medical specialties, however, appear to be underutilised in specialist surgery, an area where they predominate in the USA. They may have a greater role to play in cardiothoracic surgery. Physician Associates can complement other AHPs and surgeons in the delivery of high-quality care to cardiothoracic patients. ■

www.aapa.org/about/history/
Retrieved 2nd November 2022

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www.fparcp.co.uk

COLLATAMP® G

Gentamicin collagen resorbable implant

Haemostasis with antimicrobial action and protection[1]

Collatamp® G is a gentamicin-collagen implant used during cardiac[2,3,4], vascular[5], orthopaedic[6,7] and gastro-intestinal[8] surgery.

Dimension & Composition of Collatamp®G				
Size (cm)	Bovine collagen		Gentamicin sulfate (base)	
	mg/implant	mg/cm²	mg/implant	mg/cm²
5 x 5 x 0.5	70	2.8	50 (32.5)	2.0 (1.3)
10 x 10 x 0.5 5 x 20 x 0.5	280		200 (130)	

Collatamp® G is used for local haemostasis of capillary, parenchymatous and seeping haemorrhages in areas with a high risk of infection (determined by the surgeon on a case-by-case basis, including patient-related, surgery-related, and physiological factors).

After implantation of Collatamp® G, systemic gentamicin plasma amounts may temporarily reach therapeutic levels.

CE 0123 **Class III medical device** CE marking and identification number of the notified body.
Product conforms to the essential requirements of the Council Directive 93/42/EEC concerning medical devices.

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1 Introduction: Collatamp G is a sterile fully absorbable haemostatic device for implantation. It is composed of bovine collagen incorporating gentamicin sulfate at a locally effective dose. The product is available in three different sizes. Dimensions and composition of Collatamp G Size (cm) Bovine collagen Gentamicin sulfate (base) mg/implant mg/cm2 mg/implant mg/cm2 5 × 5 × 0.5 70 2.8 50 (32.5) 10 × 10 × 0.5 2.0 (1.3) 5 × 20 × 0.5 280 200 (130). **2 Intended use:** Collatamp G is intended to achieve haemostasis when blood comes into contact with the released tissue factors and exposed collagen fibrils. The adhesion and aggregation of platelets is induced on the collagen fibrils at the surface of Collatamp G. **3 Indications:** Collatamp G is used for local haemostasis of capillary, parenchymatous and seeping haemorrhages in areas with a high risk of infection (determined by the surgeon on a case-by-case basis, including patient-related, surgery-related, and physiological factors). After implantation of Collatamp G, systemic gentamicin plasma amounts may temporarily reach therapeutic levels. **4 Contraindications:** Do not use Collatamp G if: - a protein allergy is known; - any signs of hypersensitivity (severe allergy) to gentamicin have been observed or the patient is allergic to other aminoglycosides; - the patient is suffering from myasthenia gravis. Collatamp G should not be used in the paediatric population due to a lack of data on safety. 4.1 Pregnancy and lactation There is no adequate data from the use of gentamicin in pregnant women. Studies in animals have shown reproductive toxicity. Because of the potential risk of inner ear and renal damage to the foetus, gentamicin should not be used in pregnancy unless in case of a life-threatening indication and if no other therapeutics option is available. Gentamicin is excreted in breastmilk and was detected in low concentrations in serum of breastfed children. A decision must be made whether to discontinue breastfeeding or to discontinue/abstain from gentamicin therapy. **5 Precautions for use:** Use Collatamp G with caution in case of: - Impaired renal function - Vestibular or hearing disorders - Neuromuscular disease - Immune disease - Connective tissue disease - Advanced age - Dehydration - Electrolyte imbalance Collatamp G should be used with extreme caution if used in combination with other gentamicin-containing products. In case of combined therapy, gentamicin serum levels should be measured, and should not exceed 12 mg/L. If required, serum aminoglycoside levels may be determined during implant treatment and renal function monitored by measuring serum creatinine concentrations (particularly in patients who are elderly, diabetic, have renal/hepatic impairment, or have a history of ear infections or hearing impaired). Special caution is advised in patients with reduced renal function and patients taking other medication such as: - antibiotics that also affect kidneys or hearing (such as aminoglycosides, cephalosporins, methicillin) - anticoagulants (e.g. warfarin and phenindione) - antifungal medication (e.g. amphotericin B) - medicines used to treat muscle weakness conditions (e.g. neostigmine, pyridostigmine, botulinum toxin) - immunosuppressants (e.g. cyclosporin) - anti-cancer medicines (e.g. cisplatin) - some diuretics, such as ethacrynic acid and furosemide - non-steroidal anti-inflammatory agents to treat pain and inflammation (e.g. indomethacin) - medicines used to treat osteoporosis (e.g. bisphosphonates) If several implants are used, use of an overflow drain is recommended. Long-term continuous therapy with gentamicin should be avoided. Prolonged use may lead to the emergence of resistant organisms. There is no evidence that single use Collatamp G administration in patients promotes or induces the formation of resistance against gentamicin. Do not use the implant alone to treat a suspected or confirmed infection, appropriate systemic antibiotics must be administered. **6 Interaction with other substances:** No interactions have been reported to date. If adjuvant systemic treatment with gentamicin, other aminoglycoside antibiotics or other ototoxic or nephrotoxic drugs is necessary, the cumulative effects should be taken into account. **7 Properties:** Haemostasis is triggered when blood comes into contact with released tissue factors and exposed endogenous collagen fibrils or renatured collagen fibrils like those in Collatamp G. The adhesion and aggregation of platelets is induced on the renatured collagen fibrils of Collatamp G and the plasmatic coagulation process is accelerated. The sponge-like structure of Collatamp G stabilises the wound clot, and takes up a certain amount of blood. Collagen also promotes granulation and epithelialisation. Collatamp G is completely absorbed (estimated that in the overwhelming majority of cases, Collatamp G is completely or predominantly degraded within 4-8 weeks, regardless of the site of implantation). The gentamicin included in Collatamp G helps to prevent infections that might occur at the site of implantation caused by gentamicin-sensitive bacteria. The administration of Collatamp G might not prevent an infection with gentamicin-resistant bacteria. The risk of infection is based on individual/combination of factors. **8 Dosage and method of administration:** The implant procedure should be performed by an appropriately trained surgeon under aseptic conditions. Avoid any unsterile handling of the product before or during application to avoid contamination. Collatamp G is administrated as follows: a) Before surgery - Read the instruction for use carefully. - Check the integrity of packaging. - The product must be used as soon as the sterile package component has been opened. - Do not use if the packaging is damaged. b) During surgery - Gloves and instruments should be wetted to prevent Collatamp G from adhering to them. Collatamp G can be cut to size to fit the area to be treated. - Place a dry Collatamp G on the area to be treated, which should be as dry as possible, and light pressure applied for about a few minutes to achieve better adhesion. - Up to 3 large Collatamp G sponges (10 × 10 × 0.5 or 5 × 20 × 0.5 cm) can be used, depending on the size of the area requiring haemostasis. However, the patient's body weight should be taken into account. The number and size of the implants should be selected so that a total dose of 9 mg gentamicin sulfate per kg body weight is not exceeded. c) After surgery - Collatamp G is completely absorbed. - Timelines for complete absorption depend on the site of surgical implantation. **9 Undesirable effects:** Serious adverse reactions including neurotoxicity (vertigo, tinnitus), ototoxicity (potential hearing loss, deafness, balance loss) and nephrotoxicity have occurred primarily in patients receiving systemic gentamicin therapy. However, systemic absorption following implantation of Collatamp G is unlikely to constitute a comparable risk. Rare / very rare incidents (maximum 1 incident by sales volume of 10,000 qty.) potentially associated with Collatamp G use include delayed/impaired wound healing, local infection / secretion, haematoma, seroma, elevated creatinine levels, sensitisation/ hypersensitivity reactions, and thrombosis. Categories and ranges have been calculated based on ´probability of occurrence´ estimates using the manufacturer's risk management rating system. As a reference parameter, the probability of occurrence of an ´event per patient´ is used, which is based on product sales numbers. **10 Information/warnings:** Implants are for single use only and are delivered sterile. Implants are supplied in unit packages allowing sterile presentation. If any aspect of the packaging is damaged, sterility cannot be guaranteed. Use of the implant is then under the total responsibility of the user. Wetting Collatamp G prior to implantation may result in loss of efficacy through premature elution of the water-soluble gentamicin sulfate. Re-sterilisation of an implant by any method is prohibited. There is a risk of deterioration of the material during a second sterilisation and this risk is not controlled. Once the outer package is opened, the implant must be used or discarded. Once opened, single packs of Collatamp G may not be kept for later use. Any implant which has been implanted cannot be reused. In case of an error in use, the implant is not designed for cleaning without risk of deterioration. If Collatamp G requires surgical removal or replacement, the procedure should be performed under aseptic conditions. **11 Storage conditions:** Store in original package. Store between +4°C and +25°C. Store in a clean, dry place. Verify the integrity of all aspects of the sterile packaging. DO NOT use if open or damaged Do not use after the expiry date. 12 Disposal: Any unused or discarded product must be disposed of in accordance with local regulations in force Detailed prescribing information: Information about this product including: adverse reactions, precautions, contraindications, and method of use can be obtained by contacting SERB SA at medinfo.uk1@serb.eu. Legal category: Class III Medical Device. Distributor and legal manufacturer: SERB SA, Avenue Louise 480, 1050 Brussels, Belgium.

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Date of Preparation: December 2022

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SERB Pharmaceuticals

Congenital Heart Disease Priority Setting Partnership

Nigel Drury, Academic Consultant, Birmingham Children's Hospital
On behalf of the Congenital Heart Disease Priority Setting Partnership steering group

As outlined in a previous edition of the Bulletin (Issue 10, August 2021), the Congenital Heart Disease Priority Setting Partnership (PSP) brought together patients, parents, charities, and clinicians to establish national clinical priorities for research in children and adults with congenital heart disease (CHD). It was a collaboration between the SCTS, the British Congenital Cardiac Association, the Children's Heart Federation, and the Somerville Heart Foundation, and hosted by the University of Birmingham.

Working with the James Lind Alliance, we formed a steering group of stakeholders with a wide range of lived experiences or professional interests in CHD. As these conditions have a life-long impact well beyond surgical interventions, the scope of the PSP was focused on management throughout life, including prior to birth, in three areas of the patient and families experience:

- Diagnosis
- Treatment: medical therapy, catheter intervention, surgery including mechanical support and transplantation, and psychosocial intervention
- Outcomes of the conditions and/or treatments and the impact on patients and their families, including the physical, psychological, and social effects.

To protect potential priorities for the growing population of adults living with CHD, the steering group agreed to split the process into parallel 'child/antenatal' and 'adult' tracks after the initial question gathering stage. The PSP comprised four stages:

1. Initial public survey: Launched in June 2021, we asked: 'What questions would you like to see answered by future research, relating to the diagnosis, treatment, or outcomes of congenital heart disease?' and invited respondents to pose up to three questions. The survey was publicised online, through partner organisations, and social and traditional media. By its close in October 2021, a total of 524 patients, parents, charities, healthcare professionals, and others had completed the survey.

2. Data processing and evidence checking: Responses were collated and tagged as relevant to children, adults, or both, and those identified as out of scope were removed. The remaining questions were divided into categories and the steering group developed indicative summary questions, using an iterative process to combine similar or overlapping questions, and reword into plain, consistent language.

Of 1,373 submitted questions, 313 were deemed to be out of scope or duplicates and the remaining 1,060 questions were used to generate summary questions. These were checked against the literature and those that were already answered were removed, with 56 child/antenatal and 47 adult uncertainties taken forward to the next stage.

3. Interim prioritisation surveys: Two second surveys, one child/antenatal and one adult, were conducted in March-May 2022, in which respondents were asked to choose up to ten of the most important uncertainties. 250 respondents completed the child/antenatal survey and 252 completed the adult survey. The questions ranked most highly by clinicians and/or non-clinicians were taken forward to the final workshops.

4. Final priority setting workshops: Two workshops were held in Birmingham in June 2022, bringing together patients, parents, charities, and healthcare professionals, with a range of conditions/expertise from across the UK and Ireland. Three James Lind Alliance advisors facilitated the discussions to build consensus using an adapted nominal group technique, and across the two days, 39 participants worked together to agree the final rankings. There was excellent engagement from all participant groups, with moving personal stories and passionate informed debate. Consensus was reached relatively quickly on both days and two final Top 10 lists of national research priorities were agreed, as shown in the tables. Remarkably, six of the priorities were present on both lists, leading to 14 distinct clinical priorities: four child/antenatal, four adult and six throughout life.

CHD PSP child workshop

Beyond the PSP: a national strategy to address the priorities

Defining national clinical priorities for research provides a platform for

conducting the research that matters most and has the potential to transform collaborative CHD research in the UK and Ireland. This is the first time that the James Lind Alliance process has been applied to CHD, to give patients and their families an equal voice to clinicians in shaping the direction of research.

The Top 10s cover a wide range of clinical research areas including surgery, catheter interventions, intensive care, antenatal screening, psychology, cardio-obstetrics, electrophysiology, epidemiology, bioinformatics, pharmacology, technology, bioengineering, and transplantation. Many encompass holistic outcomes, looking beyond early mortality to improve the quality of survivorship and reduce the impact of living with CHD. Whilst diverse methodologies will be required to address these priorities, including qualitative studies, database analysis and translational research, many are well suited to clinical trials.

Whilst many PSPs publish their findings and leave it for others to take forward, we have developed a national strategy to address them through collaborative research, endorsed by professional bodies and national charity partners.

1. To establish the Congenital Heart Research Network, a UK and Ireland collaborative network for multi-centre research, focusing on clinical trials and other studies that address the priorities and have the potential to change clinical practice.

2. To set-up a national CHD Patient and Public Involvement (PPI) group, comprising engaged patient, parent, and charity members with lived experience, to contribute through all stages of research.

3. To develop specific working groups of clinicians, researchers, and PPI members, to address each of the priorities.

4. To learn from the experiences of others in conducting multi-centre CHD research and translating research priorities into funded clinical studies.

Together, we believe these represent a unique opportunity to transform collaborative CHD research for the benefit of the whole community.

For more information, visit:website: **www.birmingham.ac.uk/congenital-psp** or follow us on twitter: **@congenitalPSP**. ■

CHD PSP adult workshop

Table 1

Top 10 priorities for child/antenatal congenital heart disease research	
1	How can damage to organs (e.g. heart, brain, lung, kidney, bowel) during heart surgery in children with CHD be minimised to reduce complications, especially in those who require multiple operations?
2	How can pre- and post-natal screening strategies (e.g. scans, pulse oximetry, novel techniques) be improved to achieve greater accuracy, avoid late diagnosis, and reduce complications from CHD?
3	What are the effects of CHD, low oxygen saturations, and interventions on brain development and behavioural outcomes, and how can these be improved?
4	How can the frequency or need for reoperations be reduced for people with CHD (e.g. improved valve/conduit longevity or that grow with the patient)?
5	How can technology be used to deliver personalised care and improve outcomes in CHD (e.g. artificial intelligence, 3D printing, genomics, stem cells, organ regeneration)? *
6	What is the impact of living with CHD on mental health in children and how can this be improved through access to psychological support and other therapies? *
7	What is the impact of living with CHD on quality of life in children and how can this be improved? *
8	How can less invasive interventions be performed for CHD with the same outcomes as open-heart surgery? *
9	How can the longevity of the Fontan circulation be prolonged and the impact of complications (e.g. liver, protein-losing enteropathy (PLE), renal, endocrine, fertility) be reduced? *
10	What are the long-term outcomes and life expectancy of children born with CHD?

Table 2

Top 10 priorities for adult congenital heart disease research	
1	How can less invasive interventions be performed for CHD with the same outcomes as open-heart surgery? *
2	How can the longevity of the Fontan circulation be prolonged and the impact of complications (e.g. liver, protein-losing enteropathy (PLE), renal, endocrine, fertility) be reduced? *
3	What is the impact of living with CHD on mental health in adults and how can this be improved through access to psychological support and other therapies? *
4	How can technology be used to deliver personalised care and improve outcomes of those with CHD (e.g. artificial intelligence, 3D printing, genomics, stem cells, organ regeneration)? *
5	What are the risks and limitations associated with pregnancy, childbirth, and motherhood for women with CHD, and what information and support is available?
6	What are the best treatment strategies for heart failure in adults with CHD, in particular those with a systemic right ventricle?
7	How can the management of arrhythmias, including sudden cardiac death, in adults with CHD be improved?
8	How can the indications, timing of referral, and outcomes of transplantation and long-term mechanical support in adults with CHD be improved?
9	What is the impact of living with CHD on quality of life in adults and how can this be improved? *
10	How can the frequency or need for reoperations be reduced for people with CHD (e.g. improved valve/conduit longevity or that grow with the patient)? *

** indicates priorities appearing on both lists that are derived from the same summary questions*

Surgeons twiddling their thumbs

Jules Dussek, Past President, SCTS

A few months before we had the incredible fortune of appointing Isabelle to run the Society, we had held our annual conference in March 2000 in Islington Town Hall. On the day before the start of the conference, we had had a meeting of the Executive of the Society at the Royal College of Surgeons of England where their press officer had asked if we had any news that they could publicise. I told her that for the first time ever the number of coronary grafting operations had fallen and thought nothing more of it.

That evening as President, I hosted a dinner for Executive members in the Robens suite on the 29th floor of the tower block at Guy's. At 10 o'clock the phone rang and someone from the BBC said they wanted me to come to be interviewed on the Today programme the following morning, just a few hours away. They would send a taxi at six thirty in the morning - how could one refuse such an opportunity?

The taxi arrived on time and took Vanessa (my wife) and me, somewhat bleary eyed, to the BBC centre at White City and thence to a small waiting room where we were offered much needed coffee. Soon after arrival I was ushered into the studio where I was interviewed by Ed Stourton, fortunately a very benign interviewer. Being interviewed on television or radio is usually a challenge, there is no rehearsal and usually no discussion in advance of what is to be covered. On this occasion it was easy, for the first time in the history of coronary artery grafting the number of operations had fallen, despite a rising incidence of coronary artery disease. The obvious question was "why?" and the answer at the time was that it was mainly due to a desperate shortage of available intensive care beds. Snatched out of the air I said "surgeons were twiddling their thumbs waiting to perform operations". This phrase was readily grasped and was repeated throughout news summaries throughout the morning on all the BBC news channels including the World Service.

Over and over again one heard "Jules Dussek, President of the Society of Cardiothoracic Surgeons said 'surgeons were twiddling their thumbs waiting to perform coronary heart surgery'."

Immediately after the Today interview I was rushed from studio to studio to say essentially the same thing. Having started so early in the morning, I was able to get back to the conference in time for the start of the formal sessions but was dragged out to give an interview to ITV, a twenty second clip of this is still available for viewing now at: **www.gettyimages.co.uk/detail/video/fall-in-heart-bypass-operations-england-london-jules-news-footage/804630534**

I was then invited to be interviewed by Jimmy Young. Jimmy Young was a broadcaster/disc jockey who had a much respected regular lunchtime news and current affairs programme. He was incredibly well informed and had interviewed people from all walks of life including on several occasions Margaret Thatcher. On the way there the BBC taxi driver asked "What's it all about?" I said it was about the reduction in heart surgery for coronary heart disease, or to be more accurate it was due to a shortage of intensive care beds. Quick as a flash the driver came up with a solution, "surely you could get a little man round the corner to knock some up cheap?" A taxi driver's solution to the health crisis.

It might have all ended there, but I gave a few other minor interviews over the next few days. I was contacted by a BBC reporter with whom I had been speaking who said he hoped "I had jolly well got my facts right" because they were being severely hammered by the department of health on their reporting. A few days later I was phoned by the cardiac czar who said "You've been talking to the press again. Alan Milburn (secretary of state for health at the time) and I are fed up with going to the BBC to answer your criticism, it is not helpful and we would wish you would bloody well shut up."

I treasure that moment. ■

Thoracic Surgical Oncology Course – What do the Irish do?

Rebecca Weedle and Gerard J Fitzmaurice,
Department of Cardiothoracic Surgery, St James's Hospital, Dublin

Overview of the RCSI clinical simulation lab with participants engaged in the various surgical stations

The inaugural St James's Hospital thoracic surgical oncology course focusing on lung cancer was hosted at The Royal College of Surgeons in Ireland on Saturday October 22nd 2022. A distinguished and experienced faculty presented an overview of modern lung cancer management and surgical techniques. The course included a unique opportunity for surgical simulation in the largest clinical simulation facility in Europe at the RCSI campus in Dublin city centre.

The course began with an overview of the diagnosis, staging, and assessment of fitness for surgery of lung cancer patients followed by an introduction to VATS lobectomy, complex resections (PA/bronchus), and chest wall resections/ reconstructions. Thereafter followed the highlight of the course in the clinical simulation lab with three key stations under the careful guidance of experienced faculty. VATS lobectomy was performed on heparinised pig models, including airway assessment with flexible bronchoscopy. Participants performed chest wall resections and reconstruction using a high-fidelity simulator with a variety of materials from traditional to advanced. And finally lung blocks were used for bronchial, carinal and PA sleeve resections and anastomosis. The VATS Stupnik simulator was also available for junior trainees to develop basic VATS skills.

The afternoon session was a comprehensive overview of advances in systemic treatment for NSCLC including targeted and neoadjuvant therapies, stereotactic ablative radiotherapy in lung cancer with a unique behind-the-scenes view, and the latest evidence detailing the St James's Hospital experience in percutaneous lung ablation.

The course closed with a challenging and interactive tumour board discussion focused on two difficult cases chosen to stimulate discussion between faculty and attendees. The first was a patient with synchronous lung primaries who had a staged sleeve right upper lobectomy followed by a VATS left upper lobectomy. A number of discussion points were debated including adjuvant treatment options. The second was a patient with low volume single station N2 disease who was enrolled in the KEYNOTE-671 Phase III neoadjuvant RCT before proceeding to an open left lower lobectomy. Interestingly, both patients were delayed along their pathway due to infection with Covid-19. These cases provided ample discussion between faculty and senior cardiothoracic surgical trainees in their preparation for independent clinical practice.

The course was attended by almost all of the cardiothoracic surgical trainees on the island of Ireland (RoI and NI) with numbers limited due to over-subscription. The feedback was very positive and we hope to expand the course to trainees across the British Isles next year – please keep an eye out for notification via the SCTS weekly Bulletin next autumn. We would like to thank Johnson & Johnson for their kind educational support. ■

Faculty and attendees of the inaugural St. James's Hospital Thoracic Surgical Oncology Course

Trainees collaborating during the wetlab sessions

Can a thoracic surgeon run a lung cancer screening pilot?

The Southampton experience

Sam Amo-Afful, Cardiothoracic Surgery Medical Practitioner; Oliver J Harrison, NTN Trainee; Edwin Woo, Consultant Thoracic Surgeon; and the Southampton TLHC Delivery Group, University Hospital Southampton

Lung cancer is the third most common cancer in the UK, and the leading cause of cancer deaths globally. The two largest randomised trials of lung cancer screening, the US National Lung Screening Trial (NLST) and the Dutch-Belgian Lung Cancer Screening Trial (NELSON) confirmed a 20% reduction in lung cancer deaths in the screened population. The smaller British UKLS study recently published similar results. In 2019, NHS England launched 10 pilot sites to undertake lung health checks including the Southampton City CCG in collaboration with Wessex Cancer Alliance and the University Hospital Southampton. The Southampton programme is unique in that it is led by a thoracic surgeon.

In the initial phase, we visited and learnt from the Manchester programme who were one of four pre-existing sites with alternative funding. Southampton opted for a mobile model for participant convenience. Our objective was to engage the 'hard to reach' target population who typically are in the highest deprivation index with a generally poor attitude to their health. As a result of the unique working relationship between the Trust and a medical imaging equipment manufacturer, we were able to secure a mobile 64-slice scanner with IV capability ahead of other projects. Any spare capacity of the scanner is utilised by the Trust for other diagnostic needs. We were also able to recycle part of the salary for the project lead into training, creating a Senior Thoracic Fellow post facilitating a period of immersive experience for senior thoracic trainees working supernumerary on the consultant rota at University Hospital Southampton.

The pilot protocol was designed by NHS England. Southampton identified 22,829 people between the age of 55 and 75 with a smoking history. They were invited to attend a one-stop-assessment. The lung health check involved a questionnaire-based interview with a nurse, cardio-respiratory observations, and then spirometry. The patient's risk of developing lung cancer was quantified using the Liverpool Lung Project (LLP) or PLCOm2012. Participants were offered low dose CT-scan (LDCT) if the calculated risk was greater or equal to 2.5% or 1.51% respectively. Pulmonary nodules identified was followed up in a protocolised fashion.

From the outset we realised in order to deliver this service to our local population, staffing requirements would be prohibitively costly. Therefore, our programme was designed with automation in mind.

We are fortunate that the IT directorate at University Hospital Southampton is a global digital exemplar. A bespoke piece of software named TARLUN was created linking the existing IT infrastructures at the Trust to the new Southampton TLHC programme end-to-end. Participants are invited according to their GP surgeries, scheduled to manage scanning capacity. Mailing of invitations is automated through TARLUN. Administrative staff then pre-screen responders for eligibility and booked their one stop assessment and LDCT. TARLUN runs the assessment clinic (with nursing staff entering data), calculates risk and requests the LDCT. Scanning is performed immediately. All participants are offered an opportunity to participate in several locally run research projects.

LDCT images are automatically uploaded to a third-party computer aided diagnostic platform, with objective measurements of all abnormalities quantified before returning to our Trust's PACS. We believe automated nodule detection with volumetric measurement improves the efficiency of our radiologists in reporting and has fundamentally changed the way they work. Not only do they report the scans, they also determine the onward pathway of our participants supported by TARLUN and the NHS England derived protocol. Onward referrals are automatically made by TARLUN. Only a minority of images are discussed in the weekly TLHC MDT meeting.

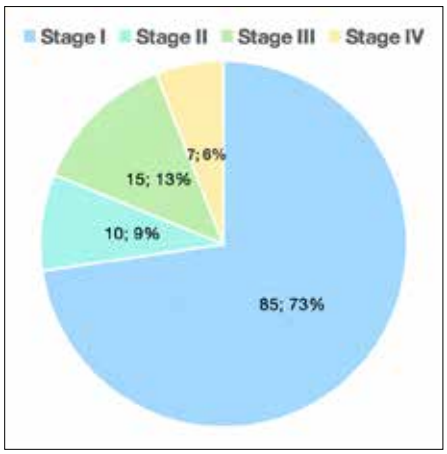
As of June 2022, 7,754 patients had attended. Of these 4,562 (59%) were invited for a follow-up scan and 820 (11%) of the follow-up patients required a second follow-up scan. 1,163 (25%) of the attendees have been referred onward as defined in Table 1.

Table 1: Onward referral destination of screened patients with clinically significant findings

Referral destination	Number of patients (% of total referred)
Lung 2 week wait	248 (21%)
Other 2 week wait	111 (10%)
COPD	554 (48%)
ILD	145 (12%)
General respiratory	28 (2%)
Tuberculosis	7 (0.6%)
Bronchiectasis	23 (2%)
Vascular	47 (4%)

117 (1.5%) of screened patients were diagnosed with lung cancer and the staging differential is shown in Figure 1. 73 (1%) of the screened patients have been referred for surgical resection. Alongside our clinical data collection, we ask patients to complete a formal feedback survey which has been completed by over 1000 of the attendees. 98% of attendees rated our service as good or excellent.

Figure 1: Screen detected lung cancer stage (n, %)



The delivery group has learnt a lot through this endeavour. We realised engagement and buy-in from primary care is crucial to the success of the programme. The most challenging aspect of setting up the programme is to convince already stretched colleagues to accept more referrals. CT scanning of the thorax results in a large number of incidental findings. There are also financial considerations and additional money has been made available by the national specialist commissioning team for investigation and treatment of all thoracic pathologies.

Targeted Lung Health Check was recently recommended by the National Screening Committee with anticipated national roll-out by 2026. Our project must evolve to serve a different participant demographic and engage with multiple new service providers as we start inviting participants from our entire catchment area and beyond. There is much anxiety over radiology reporting capacity for the national roll out. Nonetheless, TLHC will improve lung cancer patient care and we will work tirelessly to deliver this. Finally, an estimated 30% increase in surgical referrals for early stage lung cancer will bring with it the need for more thoracic surgeons over the next 5 – 10 years. Similarly, the expansion of robotics and image-guided techniques will certainly help facilitate surgical management of these smaller, early stage nodules. Segmentectomy is a hot topic in the wake of the JCOG 0802 trial. These certainly are exciting times for thoracic surgery. ■

Cardiothoracic surgery as a student at Royal Papworth Hospital, Cambridge

Mostin Hu, Medical Student, Royal Papworth Hospital, Cambridge

Aman Coonar, Co-Chair, SCTS Thoracic Committee, Consultant Thoracic Surgeon, Royal Papworth Hospital, Cambridge

Exposure to cardiothoracic surgery is often brief within medical school. I had a one-week placement in my fifth year where we were placed at the specialty heart-lung hospital on campus. This week was divided with scheduled teaching, simulation sessions, and a checklist of different clinics and surgeries we could pick from. I was, of course, very grateful for this dedicated week, but it was too brief.

My interest in cardiothoracics began when I was ten years old. I read a novel in which the main character had cystic fibrosis. This catapulted me into medicine; I managed to convince my parents to buy me a medical encyclopedia for Christmas and I borrowed every book on medicine and the human body in my elementary school library. Through the lens of cystic fibrosis, I learned about anatomy, genetics, and microbiology for the first time. CF also introduced me to the possibility of lung transplants. I met people living with cystic fibrosis through some charity work I did with Cystic Fibrosis Canada. There was one young woman I met through this work; she spoke about the rapid decline in her health as a teenager (not much older than I was at the time), the transformative impact of her first double lung transplant, and how her life was suspended in time due to chronic rejection, leading her to be on the waiting list for a second transplant. We kept in touch over the years, and she did receive a second transplant, is now recently married and working a full-time job.

I'm Canadian and I decided to come to the UK to study medicine because I wanted to start medical school as soon as possible; Canada's medical schools are graduate programs requiring a 4-year undergraduate degree first. I completed my pre-clinical years at the University of St Andrews. My interest in the heart and lungs only grew as I learned more about them. When the opportunity arose for the chance to transfer to Cambridge for my clinical years, I knew I had to try. Royal Papworth Hospital had recently moved onto the Cambridge University Biomedical site, so it was like a perfect match. I was ecstatic when I was offered a place in Cambridge and so incredibly excited to have a leading heart-lung hospital on my university campus. In my fourth year (first year at Cambridge), I chose a placement in paediatric CF care and undertook a project which I presented at the annual European CF conference.

I chose to spend part of my summer between my fourth and fifth year at Royal Papworth Hospital to explore adult CF care as an extension to my fourth-year project and also observe cardiothoracic surgery. I can only describe the first time I saw a beating heart as magical. I had previously only seen the grey, still hearts in cadavers during dissection. I was also lucky to observe a heart transplant during my summer elective performed by Mr Marius Berman. The donor heart came in an unassuming cooler – something like I would use for a picnic – encased in two plastic bags and surrounded in ice. The excitement and importance of the surgery was palpable in the air that evening, and I must sheepishly admit that I did tear up and smile very widely when I saw the new donor heart reperfuse, turn pink and start beating for the first time in the recipient's chest.

When my dedicated week at Papworth in fifth year came along, I was very excited to see as many operations as I could.

On one of the days, I was assigned to observe Aman Coonar for three cases. The first case was a VATS for pneumothorax. I was welcomed in and asked if I wanted to scrub. I was then tasked with holding the thoracoscope which projected the surgery onto a large screen. Whilst I had observed abdominal laparascopic surgeries before, it was my first VATS case. The second case was an open repair of an intercostal hernia. The third case was the most exciting of all, with the removal of a large tumour taking up most of the left upper lobe. It was a technically challenging surgery due to the size of the tumour, its close proximity to the heart and vessels and partial adherence to the pericardium. I watched as the tumour was meticulously dissected from the surrounding structures. When the tumour had been freed (which I didn't know at the time), Mr Coonar asked me to feel around the tumour and say whether I could tell if the tumour was still connected to anything. When I responded, nervously, "I don't think so..?", he gave me the great privilege of checking by "delivering" the tumour out of the incision! That was the first time I touched a lung and the difference in texture between the tumour and healthy margin of lung tissue was astounding.

There are things that can be learned from textbooks, but some things can only be learned through experience. Beyond the value of seeing procedures firsthand and beginning to learn the practical skills of surgery such as suturing, knot tying, and holding the surgical telescope, I've also found it so valuable to listen to the on-the-spot decision making that occurs during cases – the troubleshooting, adaptations, and how this is communicated to the rest of the team.

I'm immensely grateful to meet supportive, interested surgeons along the way, each distinguished in their subspecialties within cardiothoracics; Mr Aman Coonar, Mr John Taghavi, Mr Samer Nashef, and Mr Marius Berman have all welcomed me into their theatres, involved me in operations, made sure I had a good view, and taught me along the way. Cardiothoracic surgery exposure in medical school is limited and whilst I may be biased, I believe it should be featured more in the curriculum. After my week at Papworth was over, I've continued seeing as many cases as I can, going in between mandatory teaching and on my weeks off. I'm privileged to have a world-leading institution on my doorsteps, with surgeons who love teaching and seem excited by their work. I hope to maximize this opportunity.

For information about medical student elective at Royal Papworth, contact **papworth.medical.electives@nhs.net** and the surgeons direct. ■

Cardiothoracic Clerkship: "Understanding the Basics"

A 10-day intensive, supervised clerkship in cardiothoracic surgery in Cork University Hospital (CUH), Ireland

Martin Ho, Fourth Year Medical Student, University College Cork (UCC)

During the summer of 2022, I had the opportunity to participate in a supervised clerkship in cardiothoracic surgery. This was organised with the collaboration of the UCC Surgical Society and Professor John Hinchion, Consultant Cardiothoracic Surgeon, CUH.

Over the course of this clerkship, I, along with several other medical students were exposed to all areas of cardiothoracic surgery. This included attending early morning ward rounds, monitoring patients in the CCU, receiving surgical skills training, and scrubbing into theatre to learn from and assist cardiothoracic surgeons at the operating table. We also attended the outpatient department, where we got the opportunity to witness patients who had recovered just weeks after lifesaving surgery. This full circle experience allowed us to witness the continuity of care within the specialty and fully appreciate the miraculous work cardiothoracic surgeons do to quite literally change patients' lives for the better.

The small group teaching with Professor Hinchion and other cardiothoracic surgeons and trainees was another highlight of the clerkship. Understanding the basic sciences relevant to cardiothoracic surgery (clinical anatomy, physiology, pharmacology) was highly emphasised. As the cardiovascular and respiratory systems are complex, it can be daunting and difficult for medical students to attempt to understand them, and they may be tempted to take the quicker route by simply "learning off" the relevant lines in the textbook. However, taking the extra time to diligently learn and understand the physiology and anatomy is well worth it as it is the foundation to understanding disease processes and treatment. It is far superior to simply "learning off" what we read in a textbook as it allows us to think intuitively and logically to enhance our clinical judgement as surgeons.

The work ethic, professionalism, and standard of teaching from all staff in the cardiothoracic department was phenomenal and left a deep impression on me. I felt welcomed and valued as a member of the team. I am very grateful for this and am inspired to continue to maintain the high standards set before me and be the very best surgeon and teacher that I can be.

While I already had an interest in pursuing a career in cardiothoracic surgery, this 10-day clerkship transformed this interest into a desire and passion for the specialty! ■

Universal adoption of TAVI to intermediate/low risk and younger patients with aortic valve disease?

A word of caution and call to action

Marjan Jahangiri, Professor of Cardiac Surgery, St. George's Hospital, University of London
Madalina Garbi, Consultant Cardiologist, Royal Papworth Hospital, Cambridge
Norman Briffa, Consultant Cardiac Surgeon, Sheffield Teaching Hospitals NHS Trust
Joy Ellery, Past Lay member Southwark. NHS South East London Clinical Commissioning Group

All co-authors have been members of NICE Guideline Committee, Adult Heart Valve Disease

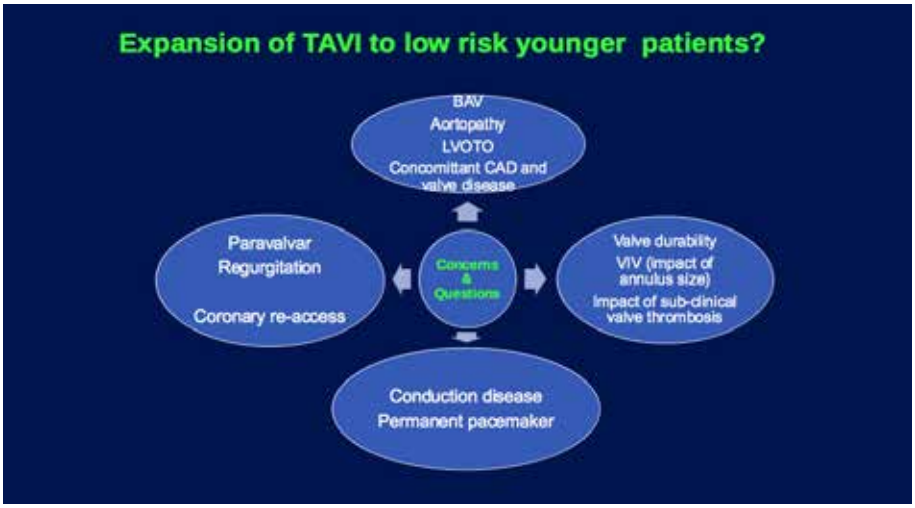
The Transcatheter Aortic Valve Implantation (TAVI) population have progressed from inoperable, to high, intermediate, and most recently low surgical risk. All the trials comparing TAVI to Surgical Aortic Valve Replacement (SAVR) have concentrated on risk stratification based on the risk of death after surgery. However, the perioperative risk of dying predicted by Euroscore and STS risk stratification score have overestimated the risk of death after surgery. Therefore, the indications and basis for TAVI based on risk stratification in the trials which have informed the published guidelines are flawed. Between 2013 and 2018, in the UK series where 90% of the cardiac surgical units took part, 31,277 patients who underwent SAVR +/- CABG were studied. Mortality for SAVR was 1.9% and for SAVR+CABG was 2.4% in a consecutive series of elective, urgent and emergency operations (Jahangiri M, et al. BMJ Open 2021;11:e046491).

Several exclusion criteria have been used which do not reflect real world practice. These include bicuspid aortic valve, aortopathy and aneurysm of the aortic root and ascending aorta, left ventricular outflow tract obstruction, complex coronary artery disease and moderate-severe mitral and tricuspid regurgitation. Furthermore, the design of all of TAVI and SAVR trials is non-inferiority which exposes the patients to clinical experiments without any assurance that the experimental arm is not worse than the standard treatment and without really exploring whether it is better.

Primary considerations should be given to life expectancy and valve durability. There is plenty of data on durability of tissue valves which is inversely proportional to age at implantation. There is a distinct increase at ten years in structural valve deterioration. In the UK, a 50 year old female is expected to live 34 years and a 70 year old male 14 years. The 15-year risk of reoperation in a 50 year old and a 70 year old is 30% and 10% respectively.

PARTNER 3 trial of low risk patients randomised 454 SAVR and 496 TAVI patients with an STS score of 1.9 and Euroscore II of 1.5. It showed that the composite of death, stroke and re-hospitalisation was significantly higher in SAVR compared with TAVI at 12 months (Mack et al. NEJM 2019;380:1695-705). However, PARTNER trialists have since reported the 5-year outcome of PARTNER 2 trial of intermediate risk patients where 1,021 SAVR were compared with 1,011

"The initial advantages that TAVI has over surgery is lost after the first 12 months, with the outcomes in the TAVI group becoming progressively worse after two years."



TAVI patients with an STS score of 5.8 (Makkar et al. NEJM 2020;382:799-809). The cumulative plots for both death and stroke crossed over in favour of surgery at 36 months. At 2 years, results were better in the SAVR group for 10 of the 17 reported outcomes and at 5 years, 16 of the 17 outcomes were better in the SAVR patients. A pooled meta-analysis of time to event over 5 years for all randomised controlled trials confirms the PARTENR 2 trial data (Barili et al. EACTS 2022;61:977-987). Some of the details in these trials warrant attention. It is reported that TAVI may result in less patient-prosthesis mismatch than SAVR. However, in the intermediate trials, 80% of TAVI valves were >29mm, whereas, 80% of SAVR valves <23mm which may account for more favourable patient-prosthesis mismatch in the TAVI cohort. Furthermore, in the NOTION trial, transprosthetic gradient for TAVI was 9 and 13 mmHg in SAVR. Is this really clinically important?

Regarding selection criteria introducing possible bias in the low risk trials, all the patients had high gradient severe AS with good ventricular function. Few women were included, where in real world practice woman comprise >50% of AV disease. Were they excluded because of small annulus and small peripheral vessels? Also, it seems that the investigators missed the low flow low gradient population.

Other outcomes determining mortality and long term quality of life include left bundle branch block (LBBB). New onset of LBBB is up to 24% at one year in TAVI compared with 8% in surgery. Similarly, the incidence of pacemaker implantation is higher in the TAVI population. In PARTNER 2 there was significant risk of death in patients with moderate-severe paravalvar leak following TAVI. In an era of precise imaging, where if there is even mild paravalvar leak after SAVR, the surgeon is required to revise the operation or the patient is followed up meticulously, it is alarming that paravalvar leak following TAVI is accepted. Furthermore, transcatheter closure of paravalvar leaks for TAVI valves is technically difficult and has been suboptimal.

The initial advantages that TAVI has over surgery is lost after the first 12 months, with the outcomes in the TAVI group becoming progressively worse after two years. In PARTNER and FRANCE-TAVI registries, patients with TAVI had three times more re-hospitalisation. The reasons for the worse outcomes of TAVI after the first year are easily explicable. Outcomes where surgery fares worse, are perioperative complications of cardiac surgery in general. They are only clinically meaningful during the initial perioperative period. The corresponding outcomes where TAVI patients do worse, namely paravalvar regurgitation, leaflet degeneration, cusp thrombosis, heart block and need for permanent pacemaker are features of the AVR rather than the delivery. They influence long term prognosis, irrespective of age at implantation and the overall risk.

The lack of follow-up data in the national cardiac surgery database weakens the case for SAVR and has resulted in proposals that increased TAVI activity should be used to deal with the post COVID long waiting lists of patients with AS.

How can the understanding of SAVR and its risks and benefits for patients and health care providers improve?

1) We need to take part in designing national registries;

2) All patients with aortic valve disease to be seen by both cardiologist and cardiac surgeon at the same time;

3) Wider adoption of minimally invasive SAVR;

4) Ensure we collect comprehensive follow-up data after hospital discharge with increased patient's involvement;

5) That comparative UK data on deaths, strokes, and hospital re-admissions after surgery and TAVI are collected and made available to inform policy and patients. ■

Concerns and questions before embarking on TAVI for low risk and younger patients

- **Regarding coronary artery disease (CAD)** – although PARTNER 2 was randomised, 14.5% of SAVRs had CABG vs 3.9% in the TAVI group
- **Regarding valve-in-valve (VIV)** – further information is required on the impact of VIV on patient-prosthesis mismatch
- **Regarding repeat TAVI or redo surgery after TAVI** – not always possible because of anatomic considerations. TAVI explantation is a difficult procedure with a high mortality rate
- **Regarding subclinical valve thrombosis** – short term clinical significance is controversial and long term is unknown and may expedite structural valve deterioration
- **Regarding moderate to severe paravalvar leak** – It is associated with increased mortality, heart failure and re-hospitalisation. Mild leak is controversial, 30% in TAVI series vs 3% is SAVR have mild leak. Moderate-severe leak increases mortality

Once Upon a Time ...

Rob Lamb, Consultant Cardiac Surgeon, Past Honorary Treasurer SCTS

I became the Treasurer to the society in 1998 having been approached by Deirdre Watson, the then Honorary Secretary. She was under the impression that I was financially adept, having raised £3m+ for Wessex Heartbeat, a charity that I set up to benefit my unit in Southampton. Nothing could have been further from the truth, frankly! But I was happy to have a go as it had the potential to be a good way to stay in touch with my cardiothoracic mates up and down the country, having been forced into a very early retirement by an injury to my median nerve in my dominant hand in 1996.

At that time, the society was managed from an administrative perspective by a company, which I shall refer to as Robin Services, so that they remain anonymous here. I understand that Jules Dussek asked his accountant to have a quick look at the society accounts during his tenure as President, only to conclude that the society was managing to keep Robin Services in a very healthy state financially to the detriment of the society. That was in line with the perceptions of many society members! I remember attending the conference in Dublin in 1997 to discover that the hotel room rate Robin Services charged me was about 25% above that published on the back of my bedroom door in the hotel. The society had only £30,000 in the bank at that time, its annual meetings were not the most popular events in the calendar and the society was unable to fund any significant scholarships or educational activity for trainees from its own monies.

I was keen to rid the society of Robin Services and presented my case to the Executive. Thankfully, it was agreed that we would go for it and an initial framework was developed. Planning took a little while and, as the only non practicing surgeon on the Executive, my role as Treasurer had expanded somewhat and even included editing and publishing the society Bulletin. I created a job description for an administrator, secured office accommodation and 'spied' on Robin Services in order to fully understand what was necessary to both manage the membership and organise the annual meeting. Once we were confident that we should proceed with independence, I had to secure as much data as we could from Robin Services, a task that was not easy as they were incredibly possessive over their systems and records. **Enter Isabelle!**

Jules and I interviewed several candidates for the post of Society Administrator early in 2000. Isabelle was without doubt the stand out candidate and was offered the job. Only after she had accepted the role did I confess that we didn't really know what we were doing and it would undoubtedly be an uphill struggle to achieve our goal. Luckily, Isabelle was up for it. We severed our ties with Robin Services and Isabelle moved into an office at the Royal College of Surgeons in Lincoln's Inn Fields. We were off!

Isabelle surpassed our expectations. She was enthusiastic, diligent, keen to learn and willing to work above and beyond her contract. She structured and maintained the database of members, banked subscriptions and organised all the Executive meetings. She ran her own office. She was SCTS.

Graham Cooper was appointed to a new role of Honorary Meetings Secretary and was primarily responsible for the scientific aspect of the annual meeting. I organised the exhibition and Isabelle managed to do all the donkey work and keep both Graham and me in check. We would meet the day before each and every Executive meeting and pore over our spreadsheets. We aimed to change the reputation of the SCTS annual meeting into something that was respected, educational and entertaining. It was hard work but we also had a lot of fun in the process.

I'd like to think that we achieved our aim back in those early naughties. As an example, some of you will remember my favourite meeting in Guernsey in 2004. The exhibition for the first time had non-surgical exhibitors (a jeweller selling VAT free items to exhibitors and surgeons alike, a florist selling Mother's Day bouquets for forgetful surgeons and Montoya's F1 simulator for surgeons with massive egos to try). The annual dinner was F1 themed with, chequered flag table cloths, F1 team caps for each diner and a scalextric competition on a giant 4-lane track for the after dinner entertainment. There was a sailing regatta the following day for those who were brave enough to tackle racing with a hangover. I should also say that the science, as had now become the norm at the SCTS meeting, was excellent. Isabelle managed the entire organisation of delegates impeccably.

I am extremely proud of our appointment of Isabelle in 2000. She has been fantastic throughout her 22 year tenure. I only had the pleasure of working with her for just over five years until I moved on in 2005 but we have kept in touch. Under her stewardship the society has grown immeasurably, to include members of all disciplines of Cardiothoracic care. She has SCTS running through her veins and unwittingly has immeasurable knowledge on the workings of a society such as ours. It has undoubtedly been an enormous amount of hard work for her. It is not easy dealing with surgeons, all of whom expect high standards, whilst some can be grumpy to say the least.

So, another chapter is starting in the life of Isabelle Ferner. Thank you Isabelle for being the rock of SCTS for such a long time and guiding all those committee members, officers and Presidents to do what is right by SCTS. You are a star!

Happy memories … ■

Isabelle Ferner pictured with Narain Moorjani, Rob Lamb, Jules Dussek and Simon Kendall during the BORS Meeting on 30th September 2022

C.A.T.S. VEST

Cardiothoracic Unisex Vest

Patent Pending

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Connecting The World Through Education: The 2023 Royal Brompton Hospital Virtual Grand Rounds in Thoracic Surgery

Jacie Jiaqi Law, ST1 in Cardiothoracic Surgery, Royal Victoria Hospital, Belfast
Aina Talaya Pons, Junior Clinical Fellow in Thoracic Surgery, Royal Brompton Hospital
Annie Phillips, Thoracic Surgery Education and Research Coordinator, Royal Brompton Hospital
Reina Layug, Thoracic Surgery Education and Research Coordinator, Royal Brompton Hospital
Professor Eric Lim, Consultant Thoracic Surgeon, Royal Brompton Hospital

The concept of the virtual Grand Rounds in Thoracic Surgery at the Royal Brompton Hospital originated from the point of need where most thoracic centres around the world have an ongoing in-house education programme, with duplicative efforts and often junior led and presented lectures to a worldwide interconnected professional education series by world leaders in the field.

As an internationally renowned institution for thoracic surgery, the Royal Brompton Hospital dedicates itself to the spirit of excellence through the conduct of world-class thoracic surgical research and education. The virtual Grand Rounds in Thoracic Surgery has become a prestigious tradition since establishment in 2020 inviting global leaders of the field to provide a focused 15-minute lecture accompanied by 15 mins deep dive interactive discussion on topics dominating the field of thoracic surgery, oncology, respiratory medicine and allied sciences to an international audience weekly on Fridays at 8.00 am or 12:00 (North America months).

From January to October 2022, the virtual grand rounds received a total of 1,052 registrants hailing across 88 countries. 1,777 attendees formed our weekly live audience with 8,920 extended audience perusing our archived lectures giving a total audience reach of 10,697.

The 2022 chapter witnessed the delivery of seminal lectures by eminent speakers including Professor Nasser Altorki from Weill Cornell Medical Centre United States and Dr Shun-Ichi Watanabe from the Japanese Lung Cancer Surgical Study Group discussing the results of two titan randomized control trials – CALGB 140503 trial and JCOG 0802 trial, which has renewed the world's interest in sub lobar resection for early stage 1A non-small cell lung cancer (NSCLC). Along the paradigm of lung preservation and minimally invasive approaches, the Rounds captured renowned figures such as Dr Dominique Gossot and Dr Alan Sihoe sharing principles of segmentectomy and next generation uniportal VATS technique. Our patron speakers from the UK and US also demonstrated advances and application of robotic thoracic surgery in lung cancer resection, thymic tumours and thoracic outlet syndrome.

Highlights include a multidisciplinary panel of speakers exploring the multimodal management of early and locally advanced NSCLC. In the era of peri-operative immunotherapy and targeted therapy, Dr Johnathan Spicer from McGill University presents the landmark Checkmate 816 trial findings which set the scene for neoadjuvant immunotherapy and chemotherapy in

"1,777 attendees formed our weekly live audience with 8,920 extended audience perusing our archived lectures giving a total audience reach of 10,697."

combination with surgical resection for stage 1B to 3A NSCLC. Dr Julia Rotow from the Dana Faber Cancer Institute explores actionable genomic targets such as tyrosine kinase inhibitor agents in the quest to shift unresectable stage 3 NSCLC to resectability. The series also discusses oligometastatic disease spectrum in depth with Professor David Jones and Professor Daniel Gomez from the US Memorial Sloan Kettering Cancer Centre, both providing expert insights into local consolidative therapeutic options including surgery and radiotherapy. We explored the realm of innovative interventional radiology and radiation oncology such as ablation strategies and proton beam therapy for NSCLC. Finally, we have a rich collection of thoracic surgery classics such as lung cancer screening, preoperative risk assessment, lung volume reduction and chest wall surgery.

It is with great pleasure to announce that The Royal Brompton Hospital Virtual Grand Rounds in Thoracic Surgery is live for 2023! We extend our sincere gratitude to Medtronic, AstraZeneca and Johnson & Johnson for their continuous support and sponsorship to democratise education and removing borders, making it available to any surgeon, trainee or healthcare professional anywhere in the world. The quality of the lecture series has been acknowledged by the UK Royal College of Physicians awarding 2 CPD/CME points for live attendees.

The team behind the Royal Brompton Hospital Thoracic Surgery Virtual Grand Rounds is committed towards delivering one vision – to convene leaders in thoracic surgery and medicine on a single platform to educate residents and students across the world to connect global minds. We hope to forge a collaborative academic community through future development which includes establishing a recognized network of UK regional and international ambassadors championing thoracic surgery education in year 2023. Join us on our wonderful venture and we look forward to seeing you at our weekly educational webinars! ■

www.drericlim.com/brompton-grand-rounds

Surgical Skills To Inspire Careers in Surgery (SSTICH)

Dr Francesca Leone, Course Director and Founder of SSTICH, Castle Hill Hospital, Hull
Professor Mahmoud Loubani, Director of Surgical Skills, Hull University Teaching Hospitals

The Hull Suture Centre at Castle Hill Hospital has received £9000 funding from the Grassroots in Surgery Scheme by the Royal College of Surgeons of England (RCSEng). Surgical Skills To Inspire Careers in Surgery (SSTICH) is a surgical skills course aiming to widen access to surgically oriented careers in Hull. It is aimed at sixth-form students from widening participation backgrounds to teach practical skills and develop their understanding of the diverse careers available in the surgical department and healthcare.

The RCSEng Kennedy Report highlighted work by Kumwenda et al that demonstrated that individuals from lower socioeconomic backgrounds are the least likely to become surgeons. We know that to have a workforce that represents our patients we need to promote diversity in terms of socioeconomic groups among other factors. This is not only important in the clinical environment but for the research and quality improvement schemes which evolve patient care. Those from working-class backgrounds in our profession have an invaluable understanding of issues facing patients from the same social group, both as inpatients and in the community. Furthermore, with surgery being a practical as well as cerebral profession, we may find that the best operators come from backgrounds where practical skills have been imparted from a young age.

I started teaching on the RCSEng Surgical Skills for Students and Foundation Doctors course as faculty as soon as I was eligible. After the day of teaching I looked at the register and noticed we had a sixth-form student attend the day. What shocked me was the fact that they were able to pay the course fee, which would have been outside the realm of possibility for me at that age. A surgical career also seemed similarly impossible. As a woman, a previous young carer and having grown up in a deprived area, I am aware of the barriers and difficulties encountered in entering medicine and considering surgery in general let alone Cardiothoracic Surgery.

The life of a Cardiothoracic Surgeon: careers talks as part of the SSTICH programme featuring Surgeons, Operating Department Practitioners, Scrub Nurses and Surgical Care Practitioners

Gloving and Gowning: teaching key surgical skills and practical sessions form the basis of the SSTICH course

Hull itself has a national reputation as a deprived city. 45.2% of the population meet the criteria for the "most deprived" decile on the index of multiple deprivation which encompasses income, employment, education, skills and training, health and disability, crime, and living environment. 26.4% of children under 16 in Hull live in absolute low income and 30.7% live in relative low income. 6.7% of the population claim benefits, in comparison to the 4% national average, with 14,215 children in the city living in benefit claimant households.

The SSTICH course is designed to expose a young person to surgery and the allied careers of the extended surgical team

including operating department practitioner, surgical care practitioner and scrub nurses. This allows the students to learn more about the medial and allied health practitioners through talks by professionals and potential entry routes. They also have the opportunity to have a go at basic surgical skills such as gloving and gowning, suturing and knot tying.

We first trialled the format in April 2022 and again in July with a local comprehensive college to glowing feedback from students and teachers alike. We applied to the Royal College of Surgeons England Grassroots Scheme for funding and achieved a grant to cover six sessions over the 22/23 academic year. We have now reached out to more schools to join the programme in key areas of Hull. Achieving funding was crucial for the scheme, as surgical skills courses are not inexpensive, and we don't wish for young people or the parents to have to pay for the course, or for a packed lunch if the young person is in receipt of free school lunches.

The surgical skills element of the course is led by the Surgical Skills Director for Hull University Teaching Hospitals, Professor Loubani, Consultant Cardiothoracic Surgeon. It was important to me that we showcase the variety of surgical specialities that operate within the multi-disciplinary team: surgery is not just surgeons after all. We have a member of each allied profession representing their speciality at the course giving informational talks and acting as course faculty. As the course grows, the plan is to include Perfusionist and Anaesthetic colleagues to the programme. We are exceedingly thankful to the Department of Cardiothoracic Surgery for their support with this project. From filling the faculty with keen tutors to delivering talks to students on the passion they have for their profession: even after 12-hour operations on a night shift!

In terms of widening access to surgical specialities, this is just a start. There is much more work that needs to be done in terms of supporting students once an interest is expressed both pre-medical school and through their years in higher education. SSTICH isn't closing the gap, but it's a start. ■

Keen to be involved in a thoracic surgery research project?

Are you sure?

Prof Eric Lim, Consultant Thoracic Surgeon and Professor of Thoracic Surgery, Royal Brompton Hospital, and Imperial College London (NTRII Co-Chair)

Paulo De Sousa, Senior Research Nurse, Royal Brompton Hospital (NTRII Co-Chair)

Dr Aina Pons, Junior Clinical Fellow, Royal Brompton Hospital (NTRII Secretary)

It's common for trainees to approach us with a burning desire to undertake research with sights set on podium presentations, publications, and career progression, but few realise how much time, effort, commitment and resilience is required.

Before you embark on a research project, you need to ask yourself a few questions. Do you want to do a high-quality project that answers questions well or simply a publication? If it is a high-quality project, how keen are you to learn how to write, re-write and revise a protocol to articulate your ideas (some have required over seven versions of correction)? Are you able to follow guidelines and adapt to standard procedures? How much time do you have to get approvals from national bodies or rummage through files and care records to collect quality data? Are you able to regularly attend feedback sessions to provide weekly updates on your work progress? And most importantly, how many times are you willing to write, re-write and format your manuscript for submission to multiple peer-reviewed journals?

If you think the previous paragraph is too much effort, stop and seek other avenues for your development. On the other hand, if you are still interested in conducting high quality research, we have a tailor-made solution to help you.

The National Thoracic Research Improvement Initiative (NTRII) is a group of research facilitators led by Professor Eric Lim and Mr Paulo De Sousa at the Royal Brompton Hospital. The aim is to provide weekly guidance and help to prospective researchers to produce high-quality research.

We meet regularly on Mondays, at 9am via Microsoft Teams, with short presentations of ongoing research, followed by mentoring with Professor Lim who will provide feedback and guidance to improve the quality of your research.

NTRII takes a very didactic approach starting with a protocol for conception, from selecting the right topic, design, statistical analysis, all the way to publication.

NTRII has conducted more than 30 meetings and supported 14 different projects. So far, it has led to 6 oral and poster presentations at major national and international conferences (including one award winning), and one publication in major peer-reviewed journals, with six manuscripts awaiting decisions for publication.

Still interested? Are you sure? If so, just drop us an email **ntrii@rbht.nhs.uk** and let's get started! ■

National Cardiac Surgery Clinical Trials Initiative

Sarah Murray, National PPI Group Chair, National Cardiac Surgery Clinical Trials Initiative
Gavin Murphy, Consultant Cardiac Surgeon, Glenfield Hospital

The National Cardiac Surgery Clinical Trials Initiative has continued to be busy over the summer period and some of our Clinical Study Groups have now merged following realignment.

- CSG3 "Heart Valve Intervention" group has merged with CSG4 "Minimally Invasive/ Hybrid/Percutaneous techniques" and has been renamed "Minimally Invasive and Heart Valve Surgery" led by Enoch Akowuah with Co-Lead Will Woan.
- CSG9: "Frailty, Sarcopenia and Chronic Conditions" group has merged with CSG1 "Long Term Outcomes of Quality of Life" led by Mahmoud Loubani and Sarah Murray.

A closer look at CSG Activity

Following these recent changes, we would like to hear from you about how you feel your group is progressing, what is good and what could be better? In addition, do you have a research question you would like considered by one of the groups? Is there a burning issue for which you would like a wider discussion? Sometimes participation in PPI sparks thoughts and ideas that benefit from further explanation but other meetings inhibit opportunity to do so.

Please send us an email, long or short, telling us what you think and any queries you may have.

Over the many months since this initiative began, the members of the public willing to support research and comment when needed has been of significant quality and the commitment to the initiative is impressive.

We are, however, so good at what we do we are being approached by people and organisations outside the CSG to help them on an ad-hoc basis.

This needs a conversation. On the one hand we are a small group and our focus is cardiac surgery, on the other we are not a generalised patient panel, such as the Addenbrooke's patient panel, for example.

There are three questions that we would like people to consider:

Clinical Study Group Updates

CSG1	**Long term outcomes and QoL** Group Lead: Mahmoud Loubani	**Submitted Project** • Project 1: Bypass surgery vs Stents in Heart Failure Surgery – Submitted to NIHR August 2022 **Projects under development** • Project 2: Decision support tool for patients with acute coronary syndrome. Next meeting to discuss timelines, work packages and funding • Project 3: Women ROMA – This trial will look at Vein grafts vs Artery grafts in women. This will require further PPI work. Submission deadline 11th January 2023.
CSG2	**Prehabilitation** Group Lead: Maria Pufulete	• Prehabilitation in Cardiac Surgery – Funded, scheduled to start April 2022 • 2 workshops to be scheduled – First workshop currently scheduled for 6th October as Hybrid event. The second workshop will be scheduled for Spring 2023.
CSG4	**Minimally Invasive and Heart Valve Surgery** Group lead: Enoch Akowuah	**Project 1:** EVH Study • WP1: Survey and Qualitative Interviews • WP2: Observational Cohort Study • WP3: Cost-effectiveness study • WP4: Instrument variable analysis **Project 2:** UK PRIMARY (previously TRANSFORM) • funded by CTSN **Project 3:** MVR Protect trial • Submitted to NIHR HTA • Progressed to stage 2 **Project 4:** Discrete choice experiment • Grant application ready for submission • PPI feedback and co-applicant added to application • Two stage process • Stage 1 submission on 13th July • Stage 1 outcome expected October 2022 • If successful – Stage 2 submission November 2022 • Stage 2 outcome expected February 2023 • Planned research start date: 1st July 2023 **Project 5:** PACES – Anticoagulation for New-Onset Post-Operative Atrial Fibrillation after CABG (PACeS) study • Funded by NHLBI/CTSN

CSG5	**Organ Protection** Group Leads: Andrew Klein Gudrun Kunst	**Project 1:** Temperature Management study • Aim for submission for NIHR RfPB November 2022 • Study start date: January 2023 • Study end date: June 2023 • First patient first visit in January • Could be funded by the RCS grant • SOECAT September external peer review (ACTAC, SCTS) – HRA submission in Oct **Project 2:** PROPHESY-2 • Submitted stage 1 to NIHR HTA • Resubmit stage 1 by 31st August – need to address comments **Project 3:** COPIA Trial • Previous unsuccessful submission – wanted results of the feasibility. • COPIA Study will be re-submitted given the results of the MARIA subgroup analysis • The protocol will be presented at the next meeting **Project 4:** TRICS IV: Funded • responding to committee comments
CSG7	**Infection Prevention** Group Leads: Ricky Vaja Luke Rogers	• A Surgical Site Infection Risk Prediction Tool to Enable Targeted Infection Prevention Strategies in Adult Cardiac Surgery – Funded, scheduled to start April 2022. • Currently on target to complete the project on time. Plan is to submit the programme grant summer 2023. • Planning a series of PPI webinars and Stakeholder meetings to present results of the work completed so far. Planning to schedule these at the beginning of 2023.
CSG8	**Data Science** Group Lead: Cathie Sudlow	• Continue to support all CSG's in the Initiative. • Meetings with CSG7 and CSG2 scheduled.

1. When approached by researchers outside the current CSG boundary, is there any appetite for people within our group to be approached to help?
2. If so, how should those requests be disseminated?
3. If not, how inflexible should our boundaries be?

There are some excellent resources in the MS Teams library about being involved in PPI: **www.nihr.ac.uk/patients-carers-and-the-public/i-want-to-help-with-research/** and these may be helpful to you.

Thank you for your continued interest and support, these trials could not be set up without you. With over 7 million people awaiting treatment in the NHS, this work is vital and you are playing a significant part in medical provision in this country.

https://le.ac.uk/cardiovascular-sciences/about/heart-surgery/national-cardiac-surgery-clinical-trials-initiative ■

What evidence is enough evidence?

Tobin Mangel, Cardiothoracic Surgery Medical Practitioner, St. George's Hospital, London

Cardiothoracic surgery is a speciality that prides itself on constantly adapting and evolving to improve outcomes and the care delivered to patients. However, despite available evidence, there is a resistance to change when patient outcomes and complication rates may be directly affected.

We pose the question to all cardiac surgeons, why does there continue to be such resistance to change when discussing INR targets in patients who have OnX valves? Two single-centre studies have demonstrated reluctance to running lower INR targets in patients who have the OnX valve in the aortic position. The reluctance is not only at a consultant level, but across an entire multidisciplinary team involved with cardiac patient care.

The Prospective Randomized On-X Anticoagulation Clinical Trial (PROACT) with warfarin demonstrated less aggressive anticoagulation targets were needed with the On-X aortic mechanical valve, yet there is unwillingness and hesitancy in every day practice to run an INR target less than 2-3. If the PROACT Trial is not sufficient evidence, then what will constitutes sufficient evidence to implement new guidelines, and abandon old and outdated practice behaviours.

We must understand the barriers surgeons hold in order to promote change and clinical practice. It is impossible to keep up with the full spectrum of research and trials that are being published and performed worldwide. Even if the surgeon is aware of the outcomes of a new trial, there may be doubts about the study results and designs, and therefore reluctance to implement change within a surgeon's own clinical practice, or an entire department's clinical practice. Experience surgeons pride themselves on having years of experience and argue that this experience is more valuable than the results of a new trial or publication. Emotions also contribute to a surgeon's resistance to change if they have had a patient experience a poor outcome due to their clinical decision making.

The OnX valve is an important example of evidenced based medicine not being followed in daily clinical practice. If we can better understand why surgeons and cardiac units struggle to change clinical practice, we may be able to create better research trials and strategies that will be sufficient enough to improve the care given to patients. ■

Mental Health and Wellbeing Matters

Sarah Murray, National PPI Group Chair, National Cardiac Surgery Clinical Trials Initiative

Narain Moorjani, SCTS President, Consultant Cardiac Surgeon, Royal Papworth Hospital, Cambridge

Sri Rathinam, Communication Secretary, Consultant Thoracic Surgeon, Glenfield Hospital, Leicester

Prof Bhuvaneswari Krishnamoorthy, SCTS Nursing & AHP Chair, Reader in Health and Social Care and Postdoctoral NIHR Research Fellow, University Hospital of South Manchester NHS Foundation Trust

The influence of mental health issues on wellbeing and on performance in cardiothoracic surgery is a growing concern. This concern has been exacerbated by the pandemic. The pressure of finding a work-life balance, as well as issues in the workplace, including bullying and harassment affect the whole team, our families and potentially the quality of care we provide to our patients. **Compassion fatigue** and **moral distress** occur as a result of all these challenges with wider impact on the health services. The Mental Health and Wellbeing Working Group (MHWG) was set up by the SCTS in January 2022 to look at these issues, see what is available, and explore how can we support our members.

We set up a strategic plan (Figure 1) to develop a support toolkit for SCTS members.

Figure 1: MHWG step-by-step strategic plan

Impact of Mental Health and Wellbeing

Mental Health and Wellbeing (MHW) has become a national front-line campaign for health workers particularly since the pandemic highlighted many work-related and personal issues that affect healthcare.

The wellbeing of our members has a direct impact on them and an indirect impact on our patients.

This **SCTS MHW strategy** is designed to:

- Develop our mental health awareness, a network of support and personal strategies to look after ourselves and others.
- Destigmatise the conversation around mental health.
- Increase awareness of the mental health support services and resources available within and outside of the SCTS for both members and non-members.
- Encourage reflection of own practices to increase resilience, resource management and signposting to further support.

Protecting self is the key

We need to prioritise our physical and mental wellbeing in and out of workplace. We need to protect ourselves against burn-out, post-traumatic stress and other manifestations of working in an often difficult, demanding and unpredictable environment.

SCTS Survey on Mental Health and Wellbeing February 2022

We surveyed our members in our Annual Conference 2022 in Belfast, of the 150 questionnaires given out 129 were returned and analysed. 51% of the respondents were medical staff and 49% were nursing and allied health professionals. Our results highlighted that 92% of the respondents wanted us to increase awareness and signposting of mental health and wellbeing on our SCTS website. 100% of respondents agreed that we should create a networking group for our members to

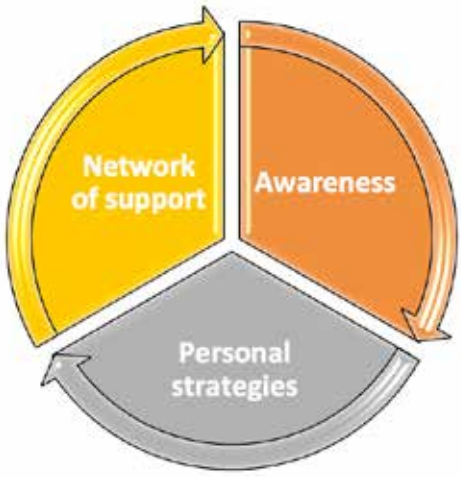

Figure 3: The key themes derived from the Mental Health and Wellbeing working group

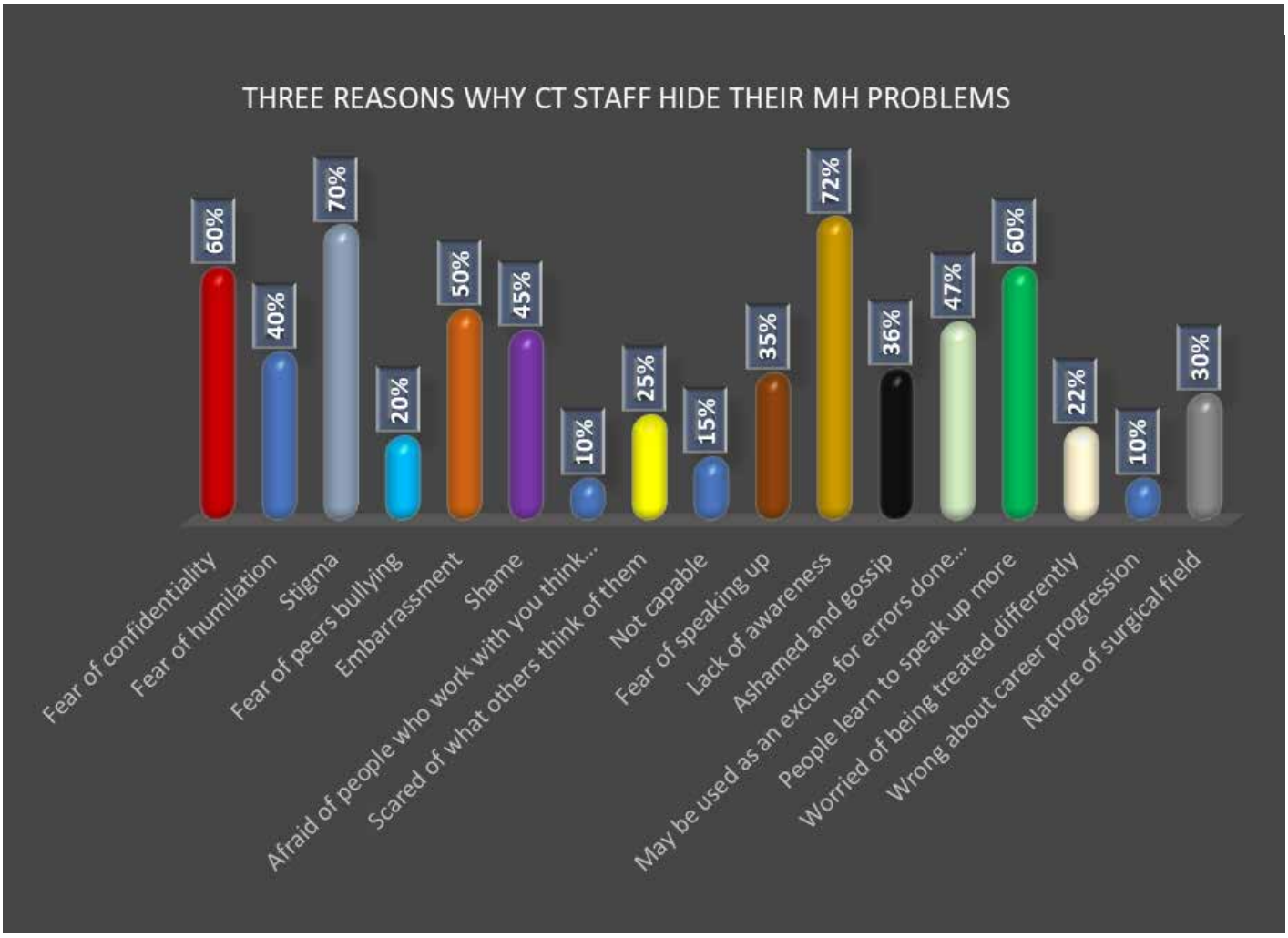

Figure 2: Three main reasons why CT hide their MH problems

offer support and a safe space to speak about mental health concerns.

Cardiothoracic surgical staff stated that they hide their mental health issues which are illustrated in the figure. The main reasons are lack of awareness, stigma and fear of confidentiality (Figure 2).

Our working group followed up the survey results with a discussion which led to three key themes which became the core of our Mental Health and Wellbeing strategy (Figure 3).

SCTS Mental Health and Wellbeing Strategy

The key themes for our SCTS Mental Health and Wellbeing toolkit are: **Awareness, Personal Strategies** and **Network of support.**

Loneliness and our mental health awareness

Loneliness affects many of us at one time or another and is both the driver for and a product of poor mental health. Our surgical society is changing very fast. The pandemic has given rise to a sense of loneliness and isolation undermining confidence in daily routines. In recent times, many of us have had far less access to loved ones due to workload. The first step in managing symptoms is to increase awareness of mental health and mental illness.

1. Awareness

Healthcare professionals need to be aware they can develop compassion fatigue, a state of tension and preoccupation with the individual or cumulative trauma encountered as practitioners. Likewise the stress of the work can lead to **burnout syndrome** which tends to be more mental than physical leading to feelings of powerlessness, hopelessness, emotional exhaustion, detachment, isolation, irritability, frustration, being trapped, failure, despair, cynicism, apathy. Likewise it can lead to a myriad of physical symptoms as well.

In addition, anxiety and depression can also be manifestations of work related stress, lack of work life balance and personal situations.

There are few simple steps for you to consider:

1. Be kind to yourself.
2. Think about what you're eating and drinking.
3. Spend time relaxing.
4. Recharge your batteries on a daily basis.
5. Maintain a sensible work-life balance combatting anxiety.

>>

2. Personal strategies

5 Simple steps to mental health wellbeing

Current evidence suggests there are five steps we can take to improve our mental health and wellbeing. These five steps could help us to feel more positive and able to get the most out of life.

1 **Connect with other people:** Creating and maintain good relationships are important for mental health and wellbeing. They can help us to build a sense of belonging and self-worth, gives an opportunity to share positive experiences and provide emotional support and allow us to support others.

2 **Be physically active:** Being active is not only great for our physical health and fitness. This can raise our self-esteem, helping us to set goals or challenges and achieve them, causing chemical changes in our brain which can help to positively change the mood.

3 **Learn new skills:** Learning new skills can also improve our mental wellbeing by boosting self-confidence and raising self-esteem, helping us to build a sense of purpose and helping to connect with others.

4 **Give to others:** Act of giving and kindness can help improve our mental health and wellbeing by creating positive feelings and a sense of reward, giving us a feeling of purpose and self-worth, helping us connect with other people.

5 **Pay attention to the present moment (mindfulness):** It can improve our mental wellbeing. This includes our thoughts and feelings, our body and the world. Mindfulness can help us to enjoy the life more and understand one's oneself better. It can positively change the way we feel about life and how we approach challenges.

Mental health first aid kit:
The Royal College of Surgeons Edinburgh started a campaign on Sep 2021 and set a Mental Health first aid kit which includes on three simple steps: **Think**, **Breathe** and **Move**.

Think
Taking a moment to do some self-assessment. We may have been busy at work and neglected something that was bothering us. Pause and think about how we are feeling. Are we happy? Have a chat with our selves (doesn't have to be out loud) and assess our state of mind.

Breathe
It sounds simple but taking ten minutes to focus on the breathing can help reduce outside distractions and give us a chance to re-centre on ourselves. Whether at home or on a break, sitting or lying down and concentrating on our breathing for a few minutes offers a good opportunity to clear our mind and get ourself ready to face the day again.

Move
We all know that exercise is important for our mental health as well as our physical health, and it is important that we don't neglect it. When we are busy with patients, exams, or training it can be very hard to find the time for a trip to the gym or a run. But we are doing our mental wellbeing a disservice if we skip on exercise. Even just a brisk walk can do a world of good.

3. Network of support

It is important we do not suffer in silence as the healthcare provider's wellbeing not only impacts our health, but our families and more importantly, our patients. Talk to a friend or family member.

Seeking peer support from someone who understands our work context and knows what it's like can be extremely helpful. There is valuable information in websites like BMA website for Doctors for Doctors and literature and podcasts about mental health support.

Employer
Every organisation has mental and well-being champions and freedom to speak up guardians. Seek help Hospital Occupational Health is important.

Support can be sought from peers and mentors as trusted seniors can offer wisdom and support. Those who are in training will be supported by he programme directors as the training programmes have professional support units .

External bodies
There are numerous resources supporting the healthcare workers which offer varying level of support.

NHS Mental and Well-being Hubs
The NHS offers the **Practioner's Health Provider** programme, which offer toolkits and support.

Canopi in Wales

There are also various website and Helplines which assist those in need of support, like:
The Samaritans (08000696222),
FRONTLINE (text support 85258),
Hospice UK bereavement (03003034434),
BMA Counselling and Peer support (-330 123 1245),
You Okay, Doc? (Text YOD to 85258).
All these offer free, confidential, 24/7 mental health SMS support from trained mental health support professionals.

Help and Support in the SCTS
The SCTS website will offer links to various, toolkits, organisation sites, self-help and summary guidance.

We welcome any thoughts or suggestions in addressing the MHW as well as any useful suggestions.

Please look out for more details in the annual meeting in Birmingham where we will have an open house event to explore thoughts, ideas and solutions to support ourselves as well as our friends and family's wellbeing. ■

"It is important we do not suffer in silence as the healthcare provider's wellbeing not only impacts our health, but our families and more importantly, our patients."


Gain time
for life.
For some patients with respiratory failure, mechanical ventilation may not be enough. Getinge Extracorporeal Membrane Oxygenation can provide time for recovery by ensuring gas exchange for days and weeks.
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Phone +44 (0) 191 519 6200 Email sales.uki@getinge.com

Training in Congenital Cardiac Surgery in the United Kingdom and Ireland

Joseph George, Trainee Representative for Congenital Cardiac Surgery, Morriston Hospital, Swansea
Shafi Mussa, Congenital Cardiac Surgeon, Bristol Children's Hospital
Timothy Jones, Congenital Training Lead and Chair, Specialty Advisory Committee (SAC)

Congenital Cardiac Surgery (CCS) in UK and Ireland is performed in designated paediatric hospitals where delivery of cardiac care is funnelled through regional networks. These Congenital Heart Disease (CHD) Networks deliver foetal, neonatal, paediatric and adult care for all CHD patients.

Training in congenital cardiac surgery historically followed the paradigm of surgical apprenticeship through fellowships. Surgeons commenced basic surgical training in general surgery, followed by adult cardiac and thoracic surgery, culminating in paediatric cardiac surgery. Specific credentialling in CCS was not necessary, with the effect that surgeons could have mixed practice in the spectrum of cardiothoracic surgery. However, following the Bristol Inquiry[1], the Kennedy Report[2] and subsequent Congenital Heart Disease Review[3] there are now specific recommendations for the training and regulation of Congenital Cardiac Surgeons.

In 2013, the General Medical Council (GMC) approved Congenital Cardiac Surgery as a sub-specialty with a dedicated curriculum and training.[4]

A recent survey of UK cardiothoracic NTNs reported 75% of trainees considered a career in CCS and of those 87% considered it up until ST5.[5] Of those trainees, 54% never experience or trained in a CCS unit and subsequently made an alternative career choice. Trainees identified multiple 'obstacles to training in CCS' including 'limited exposure', 'kept hidden as an oblivious speciality', 'not well advertised' and 'not accessible to trainees'. Trainees who undertake placements in CCS units report the experience as beneficial and positive despite limited first surgeon operative procedures.

Exposure to Congenital Cardiac Surgery during Training

Following the introduction of the 2021 curriculum, cardiothoracic training lasts seven years and is divided into 3 phases (Figure 1).[6] A working knowledge of CCS and CHD is a requirement for all cardiothoracic surgeons. This is reflected in the current cardiothoracic curriculum and in the speciality examination with approximately 10% of questions based on the management of CHD.

There is significant variability between regions in training opportunities in CCS for all trainees (Figure 2 and Table 1). Some training programs have compulsory placements in CCS, others offer it as an option and four training programs do not have a CCS unit located within their region.

As a result, the majority of trainees are not formally exposed to CCS resulting in few trainees gaining experience in CCS or considering the subspecialty as a future career, thus limiting their options and experience.

Phase 1 and Phase 2 trainees

In order to address this gap, the SAC has produced recommendations to strongly encourage (though not mandate) all trainees to undertake 3–6-month placements in the CCS Unit in their own deaneries or neighbouring centres. These subspecialty

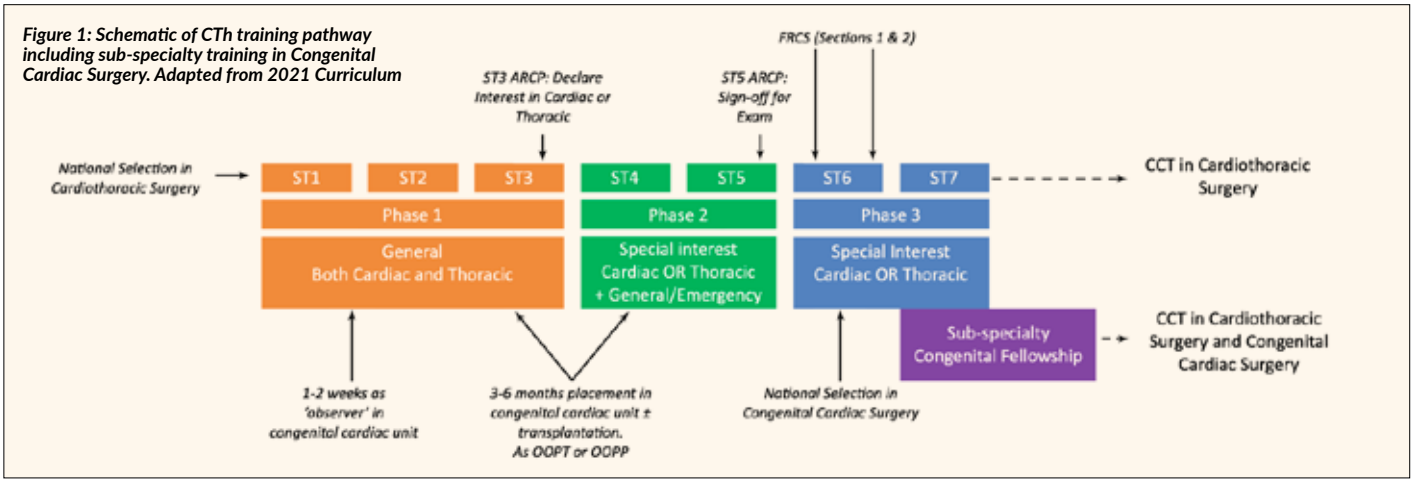


Figure 1: Schematic of CTh training pathway including sub-specialty training in Congenital Cardiac Surgery. Adapted from 2021 Curriculum

placements may be either included or excluded from the 7-year training programme at the discretion of the individual trainee and their TPD. A similar recommendation has been put in place for Cardiothoracic Transplantation.

The options for subspeciality placements should be discussed between trainee and their AES and TPD, as well as being discussed and documented at ARCP during Phase 1 and 2.

For trainees who are uncertain whether to take advantage of these subspecialty training opportunities, it is strongly recommended that they arrange 1-2 week "tasters" in both of these subspecialties during their ST2 year to inform them of the likely benefits and give sufficient time to arrange attachments in Phase 2.

Phase 3 trainees

For senior trainees who wish to pursue a career in CCS, there is the opportunity to apply for the 2-year National Training Program in Congenital Cardiac Surgery at ST7-8 or Phase 3 in the new cardiothoracic curriculum. Training follows the recently approved curriculum in CCS.[7]

Sub-specialty Training (Phase 3)

NTNs compete through national selection for a place in the two-year training programme for CCS (National Training Programme in Congenital Cardiac Surgery). The subspecialty training positions are advertised annually on Oriel[8] and person specifications are published by HEE.[9]

To be eligible for the programme, applicants should:

- be NTNs with a declared interest in Cardiac Surgery.
- have successfully completed Phase 2 with confirmed outcome 1 in the most recent ARCP.
- be successful in the FRCS (CTh) examination.
- have spent a minimum of six months in a CCS rotation.
- generally be independent operators in non-complex coronary artery bypass surgery and aortic valve replacement.

Before applying, trainees are advised to discuss their intentions with their AES and TPD, as well as the trainee rep for congenital cardiac surgery and the SAC lead for CCS.[10]

There are currently two CCS training programmes approved for sub-speciality training that cover the entire spectrum of surgical interventions (paediatric cardiac surgery, adult congenital, mechanical circulatory support, transplantation).

Birmingham / London

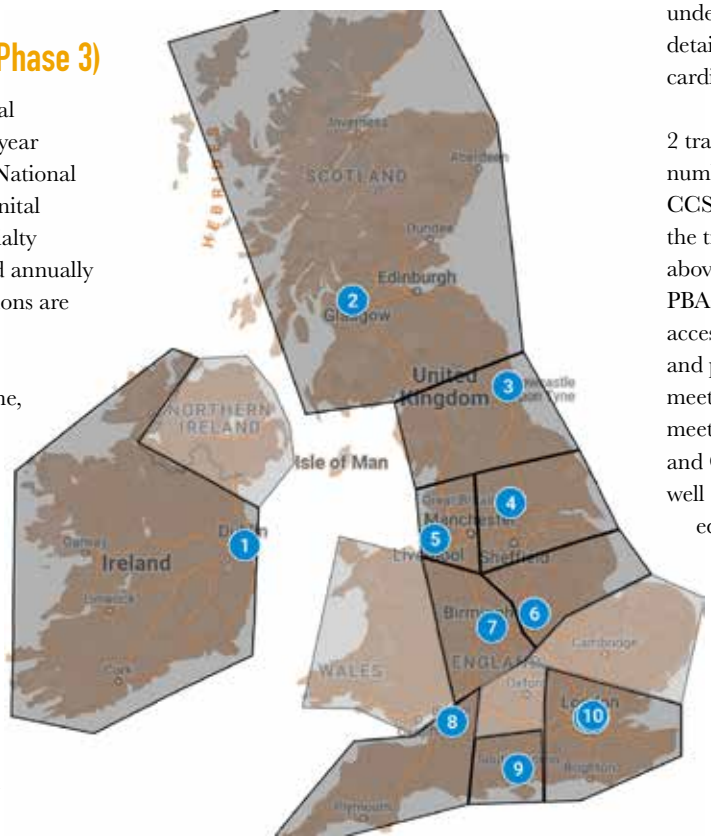
- Year 1: Birmingham Children's Hospital
- Year 2: Great Ormond Street Hospital

Liverpool / Newcastle

- Year 1: Alder Hey Children's Hospital
- Year 2: Freeman Hospital, Newcastle

For trainees completing the National Programme in CCS, the final ARCP takes into account CCT requirements for both the main specialty of Cardiothoracic Surgery and the sub-specialty of CCS, as stated in the respective curricula. Upon demonstrating satisfactory completion, the trainee is awarded certification for Cardiothoracic Surgery and CCS.

Figure 2: Map of 12 congenital cardiac centres and associated deaneries in the UK and Ireland. Deaneries without CCS units in light shade



Training Opportunities and Assessments

Many of the operations in CCS provide a unique insight and understanding of intracardiac anatomy and relationships plus cardiovascular physiology, whilst encompassing a variety of surgical techniques. The learning curve is steep as it encompasses an unfamiliar area of practice, learning new terminology and patient pathways, in a new patient group. A trainee entering the sub-specialty will find many differences compared to adult surgical services.

The success of complex congenital operations is reliant upon positive teamwork. The role of the multidisciplinary team is key to the practice, decision making and patient management. All these factors are fundamental components of Generic Professional Capabilities and underpin Capabilities in Practice as detailed in and common to both new cardiothoracic curricula.

It is recognised Phase 1 and Phase 2 trainees do not undertake a significant number of first surgeon cases during a CCS placement but they benefit from the training opportunities detailed above. There are congenital-specific PBAs and DOPS that trainees can access on ISCP. Furthermore, attending and presenting at multidisciplinary meetings, Mortality and Morbidity meetings, Journal Clubs, Governance and Quality Improvement meetings, as well as conducting audit provides further educational opportunities. Finally, it enables the trainee to make an informed choice regarding CCS as a subsequent career.

Conclusion

A period of training in congenital cardiac surgery provides a unique opportunity to learn

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advanced anatomy, physiology and surgical techniques, and needs to be made more accessible for all cardiothoracic trainees. It is a very rewarding career for those surgeons who take up the specialty. Contemporary CCS practice is at odds with its stereotype, as workload and responsibilities are shared amongst the entire team. ■

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Table of deaneries with associated congenital centres, with contact details for arranging congenital placements

Region	CCS Unit in region	Approved for Phase 3 CCS training	Phase 1 / 2 compulsory CCS training	Phase 1 / 2 optional CCS training
HE East Midlands	Leicester Royal Infirmary **ikenna.omeje@uhl-tr.nhs.uk**			Yes
HE East of England	No CCS Unit*	-	-	-
HE North East	Freeman, Newcastle **fabrizio.de-rita@nhs.net**	Yes		Yes
HE North West	Alder Hey, Liverpool **ram.dhannapuneni@alderhey.nhs.uk**	Yes	Yes	
HE South West	Bristol Children's **shafi.mussa@nhs.net**			Yes
HE Thames Valley	No CCS Unit*	-	-	-
HE Wessex	Southampton **nicola.viola@suht.swest.nhs.uk**			Yes
HE West Midlands	Birmingham Children's **p.botha@nhs.net**	Yes	Yes	
HE Yorkshire and Humber	Leeds **c.vandoorn@nhs.net**			Yes
HE London	GOSH **nagarajan.muthialu@gosh.nhs.uk** Evelina **caner.salih@gstt.nhs.uk** Brompton **a.hoschtitzky@rbht.nhs.uk**	Yes		Yes
Northern Ireland	No CCS Unit**	-	-	-
Scotland	RHC, Glasgow **mark.danton@glasgow.ac.uk**		Yes	
Wales	No CCS Unit**	-	-	-
Republic of Ireland	Children's Health Ireland, Dublin **jmcguinness2@rcsi.ie**		Yes	

**Trainees in Northern Ireland have the option of Children's Health Ireland, Dublin or a Phase 3 centre
*Those regions without a CCS Unit should contact one of the fours centres approved for Phase 3 training to arrange "tasters" or the 3-6 month OOPT/OOPP:

Alder Hey	**ram.dhannapuneni@alderhey.nhs.uk**
Birmingham Children's	**p.botha@nhs.net**
Freeman	**fabrizio.de-rita@nhs.net**
GOSH	**nagarajan.muthialu@gosh.nhs.uk**

Cardiothoracic surgery: A medical student's perspective

Ahmad Zargar, 2nd Year Medical Student, University of Leeds

I see surgeons as the top of the food chain, with cardiothoracic and neurosurgeons being the crème de la crème. In fact, this reverie goes so far that I very much look up to these individuals within their presence, even more so when I am fortunate enough to be taught by them.

I have had two opportunities to break this set of fantasies. My first-year tutor was a hand and wrist surgeon, who allowed me to observe an operation. Being a woman, a remarkable feat for those who know that only 7% of all orthopaedic consultants are female in the UK (Ahmed and Hamilton, 2021), I was humbled to be her tutee. I have vivid memories of my online tutor meetings in the late evening, where she was in hospital with her gown and scrub cap as if she would have more operations straight after the call. Thus, teaching me a lesson; to choose surgery is not to simply choose a profession rather it is to choose a way of life.

The second opportunity presented itself when I took the initiative to observe two cardiothoracic surgeries, after expressing my interest to a lecturer. Waking up at the crack of dawn for a single day, helped me comprehend the work ethic of a surgeon. The surgeon spoke slowly as if every word was thick with thought. For every patient he had a flashcard covered in ink, laden with the patient's details, one of thousands across this man's career. In addition, he was listening to the radio in French! It highlighted how there was more to his life than surgery, something I would take away that morning.

As a well-established surgeon, I half expected academic advice from him, but I received words even more valuable. He persistently, but subtly, told me to think about life's priorities and the choices one may have to make – time with family or time in surgery. All of what he said gave off a consistent conclusion, sacrifices will have to be made on this journey.

Unfortunately, the two planned operations could not take place as there were no ICU beds available; it was a Monday morning. I was told ICU usually started filling up after Thursday. This fact, as well as the thought of an entire surgical team full of incredibly skilled professionals being sedentary, blew my mind. The same surgeon who spoke of sacrifice now could not indulge in the very thing he left his family this morning for.

"We should just convert to the German system," one staff member says with his arms crossed. "They just need to have better pay so it is more attractive to young people."

Overwhelming sadness overcame me, not because I sacrificed much needed sleep for three hours of nothing, but because of how I was now seeing the 'crème de la crème' failing in a basic logistical context. I am not fully aware of what caused the ICU to fill up but from my understanding it was a mix of COVID patient technicalities and admissions from the weekend. Even as a medical student it was clear to see that there is an imbalance in the resources available and the demand on those resources. This problem has been reported as far back as 2018 (Richens, 2018) proving to it to be a systemic pressure point and not a COVID related one.

How does this affect my view of cardiothoracic surgery? It doesn't. It affects my view of being a cardiothoracic surgeon in this country. Talks of junior doctors rightly striking as well as nurses are indicators of the state of the NHS and the government's view on solving it. Simply put, I desire a healthy plethora of opportunities as a trainee and would like to reap the rewards as a consultant, with plenty of my own operations without basic hindrances. I want incredible mentors at the top of their game, who knows if many will still be there or will have left the NHS?

In the last decade, those who have left due to reasons such as citing a lack of opportunities or to undertake further training has doubled (Palmer and Rolewicz, 2022). Although, I am grateful for certain opportunities being made available, such as the SCTS' mentorship programme which I have applied for. My dream of being a cardiothoracic surgeon remains steadfast, but if I have to move country to become a better surgeon with a healthy working life then I shall do so, even if it means I have to work harder. This is a common view amongst my peers and a shame for the UK.

Fortunately, a Coronary Artery Bypass Graft (CABG) was taking place in the adjacent operating theatre. This surgery had to be done quickly since the left main coronary artery was occluded with the patient recently being COVID positive although asymptomatic. The surgical team understood the ICU situation and the team were happy to nurse the patient until a bed was made available, even though this could take 24 hours – an indication of their resolve. Following on, what I saw was life changing. The view of a beating heart in an open chest, its arrest, management of the patient's life through a combination of machine and man as well as medicine and surgery, and the intricate art that is surgical stitching. I want to do that every day of my life. I want to be a cardiothoracic surgeon. ■

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'We Are Making History'

The Inaugural Conference of the British Association of Black Surgeons: A Cardiothoracic Perspective

Nicole Asemota, NTN Trainee, East of England Deanery, Royal Papworth Hospital and Norfolk and Norwich University Hospital
Chiemezie Okorocha, NTN Trainee, West Midlands Deanery, University Hospital Coventry
Oluwanifemi Akintoye, Junior Clinical Fellow, Royal Papworth Hospital, Cambridge

On Tuesday 15th November, for the first time in the history of British medicine, the community of black surgeons in the UK gathered for the inaugural conference of the British Association of Black Surgeons (BABS) in London.

BABS UK is a new organisation sponsored by the Royal College of Surgeons Edinburgh (RCSEd) that aims to promote equality, diversity, and inclusion across the surgical field. It aims to widen participation in surgical leadership, foster long-term career development and increase representation across the profession.

Held at the Royal College of Surgeons of England building in London, the conference began with a welcome address from Ms Sarah Itam, CEO and chair of BABS. Lord Adebowale, Chair of the NHS Confederation, continued, inspiring us in his talk by reiterating the importance of being fearless catalysts of change. This set the tone of the whole conference, provoking a sense of empowerment amongst all of us in the room.

Strong representatives from both the Edinburgh and English surgical colleges were present to endorse BABS's aims. Professor Michael Griffin, President of the RCSEd and Mr Tim Mitchell, senior Vice President of the RCS England, both highlighted the importance of the colleges' collaboration; with Sir Neil Mortensen, President of the RCS England, supporting in the crowd.

Highlighting that only 2% of surgeons in the UK are of black origin, Miss Samantha Tross, trustee of BABS, led an uplifting talk discussing the current racial

Miss Nicole Asemota (second-left) and Dr Chiemeze Okorocha (second-right) with other attendees

The BABS Board of Trustees and Executive Team with Lord Simon Woolley at the podium (Left to Right: Mr Jonathan Noel, Miss Susannah La-Touche, Miss Samantha Tross, Lord Simon Woolley, Professor Frank Chinegwundoh, Miss Sarah Itam)

Professor Michael Griffin OBE - President, Royal College of Surgeons of Edinburgh

disparities within surgery. She stressed that this was not to discourage trainees, but a reminder of the importance of organisations like BABS to help support black surgeons; by facilitating effective recruitment, retention, and progression. The impact of this talk was more profound as she was the first black, female consultant trauma and orthopaedic surgeon in UK history.

Discussions around surgeons and burnout followed from the NHS Practitioner Health Service, with a new focus on the extra mental health stresses present to those who are also subjected to racism, sexism or other inequalities, and encouraged all surgeons, especially those from minority groups, to seek additional support.

Next, Professor Frank Chinegwundoh MBE and Mr Martin Griffiths inspired the audience with personal insights on their extraordinary careers. Prof Chinegwundoh enlightened us about his journey in his surgical research career – filled with perseverance, resilience, and making lasting impact.

Mr Griffiths, the National Clinical Director for Violence Reduction, whilst walking us through his own journey in surgery, took us back to reflect on the history of prominent and influential black surgeons and nurses in the UK. He reminded us of the foundations laid by others that have allowed black surgeons to grow today. An aptly timed talk to have, so soon after Black history month.

Then the gloves came off with the debate on the new ISCP Multiple Consultant Report. This potentially controversial topic was highly entertaining to the animated crowd. The Against team highlighted the potential inconsistencies of a single opinion-based report, which may be influenced by several racial or other unconscious biases. However, the defence came back, stressing the importance having multiple consultant opinions for a balanced assessment of trainees. We will leave you to guess who won!

But it is not just about us. We had great speeches about supporting the wider community. Melanin Medics, promoted their work in improving representation in surgery through their SurgIn programme. SurgIn supports and mentors those aspiring and currently in a surgical career from their foundation years to ST6. Dr Deepa Bose followed this with a reminder of the importance of the global surgical community, enthralling us on her fantastic career in Global Surgery with great insights, and how to get involved. Belvedere Financial Advisory group then took us through the least spoken-about topic within surgery – Money – having financial literacy and building 'generational wealth'.

Finally, we had our keynote speaker, Lord Simon Woolley. With a career spanning multiple prime ministers and rubbing shoulders with civil rights activists from all over the globe, Lord Woolley gave an electrifying and memorable speech on black excellence. A powerful moment was when he asked us all to stand and look around at the room and at each other, to recognise that 'we are making history'. He reminded all of us that black surgeons have a right to try at everything we can. Although we may not always succeed, we have a 'right to fail'; as long as we are given an equal chance. We speak for all at the conference when we say that Lord Woolley's speech left a mark on our minds and fired the crowd with enthusiasm.

Closing the conference, Miss Itam encouraged us to utilise the tools we are equipped with to create and shape the future of surgery; where everyone feels that they belong.

So where is cardiothoracic surgery in this spectrum? Over the past few years, black representation in the specialty has slowly grown. However, there is still much work to be done to encourage participation, recruitment, and development of black and minority ethnic doctors into the specialty. We feel it to be important to support our community in both cardiothoracics and the wider surgical world. Conferences such as these are a vital opportunity to do both. Unfortunately, there were only three of us representing the speciality at this conference, but we hope that we can double or even triple this next year; and build a strong cardiothoracic base within BABS and the black surgical community.

To end, we will quote directly from Lord Woolley with a vital message to all black surgeons, nurses, and allied practitioners involved in the surgical field:

"I see you all on the frontline. Be empowered and emboldened because our community needs you. Become the leaders we deserve, as it is not just about you. On the journey to success, take people with you. Lift them up. When that happens, we inspire a generation. Take your values, dignity, and your blackness wherever you go. Take it, embrace it, [and] own the space you're in. We are in this together." ■

The Panel Debate on the ISCP MCR

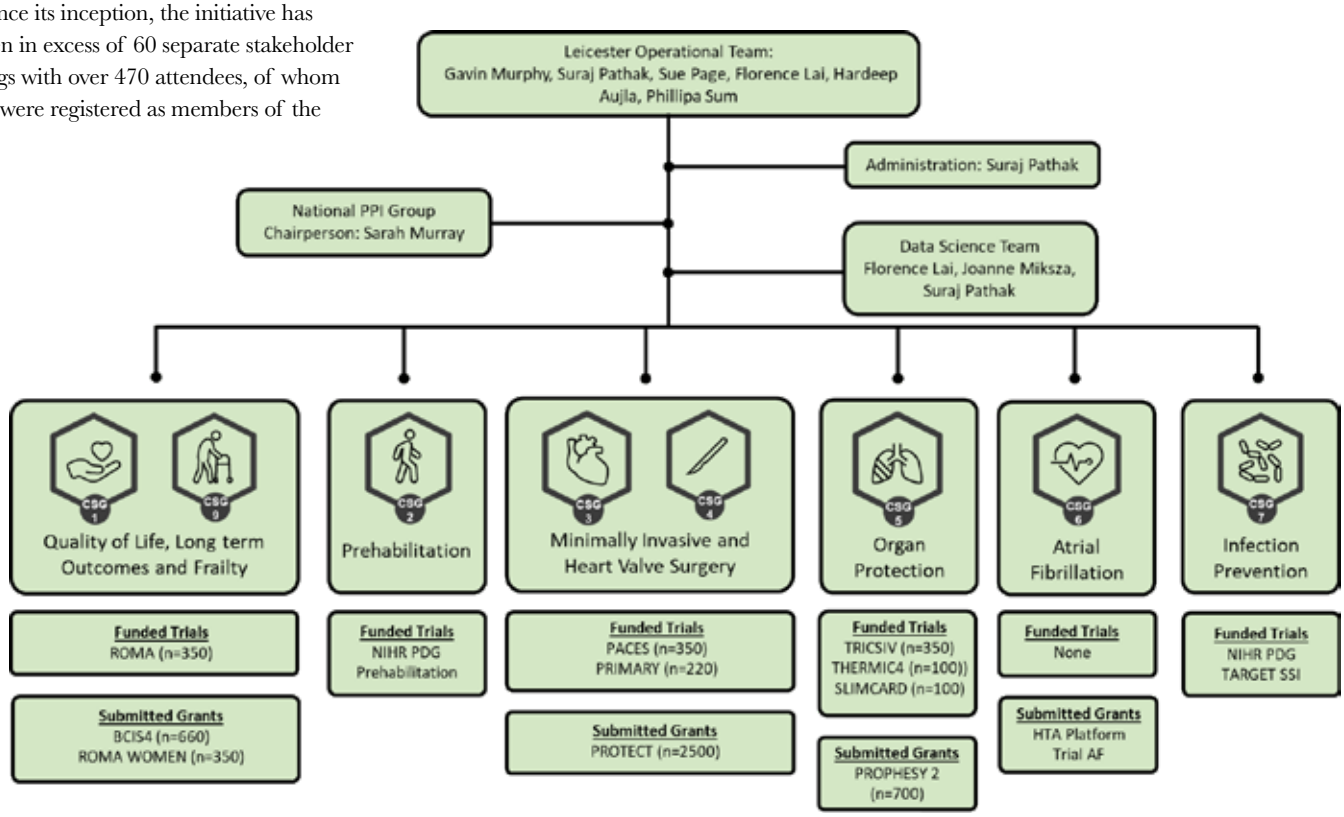
National Cardiac Surgery Clinical Trial Initiative Update

Suraj Pathak, Clinical Research Fellow, Department of Cardiovascular Sciences, University of Leicester, Glenfield Hospital
Florence Lai, Senior Statistician, Department of Cardiovascular Sciences, University of Leicester, Glenfield Hospital
Hardeep Aujla, Trial Manager, Department of Cardiovascular Sciences, University of Leicester, Glenfield Hospital
Sue Page, Team Administrator and PA to Gavin Murphy, Department of Cardiovascular Sciences, University of Leicester, Glenfield Hospital
Sarah Murray, National PPI Group Chair, National Cardiac Surgery Clinical Trials Initiative
Gavin Murphy, Consultant Cardiac Surgeon, Glenfield Hospital

The National Cardiac Surgery Clinical Trial Initiative has brought together all major stakeholders from across the UK to contribute to the development of a national patient-centered cardiovascular research programme. It has been endorsed by both the Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS) and the Royal College of Surgeons (RCS) Trials Initiative. The initiative has also received significant support from the British Heart Foundation Data Science Centre (HDSC), who aim to encourage the design and implementation of pragmatic data-enabled clinical trials.

Since its inception, the initiative has overseen in excess of 60 separate stakeholder meetings with over 470 attendees, of whom 24.5% were registered as members of the public or service users. We have collaborated with the National Cardiac Surgery PPI Group to host nine separate PPI led stakeholder meetings for each of the studies under development, with a total of 176 participants attending. From a total of nine clinical study groups (CSG), 18 separate studies have been shortlisted for development of which eight have been successful in gaining funding (see below). The significant progress made, has resulted in the Leicester CTU being recognised as a surgical clinical trial centre of excellence, which will provide the support and resources needed to continue this programme of work.

Over the course of the past year, there has been structural change with respect to the



organisation of the initiative with CSG1 and CSG9 merging to form the Quality of Life, Long-Term Outcomes and frailty group, as well as CSG3 and CSG4 merging to form the Minimally Invasive and Heart Valve Surgery group. The resulting merged groups have seen their respective members grow in number and have generated new and innovative ideas which will all be taken forward.

The past year has seen substantial progress, with the studies shown in Table 1 having successfully achieved funding. Other studies have also seen considerable progress, with the projects shown in Table 2 successfully submitted to funding committee panels.

We are committed to inclusivity. If you wish to get involved in any of the clinical study groups, either as attendees, or as study leads, bringing new ideas to the initiative, please email us on: **heartsurgerypsp@leicester.ac.uk**.

Please follow our twitter handle **@HeartSurgeryPSP** for updates on the project. ■

Table 1: Projects that have successfully achieved funding

ROMA	Working Group	CSG1
	Study	Randomized comparison of the clinical Outcome of Single versus Multiple Arterial grafts
	Study Leads	Mario Gaudino, Gavin Murphy, Mustafa Zakkar
NIHR PDG Prehabilitation	Working Group	CSG2
	Study	To co-design a prehabilitation intervention suitable for patients undergoing elective and urgent cardiac surgery
	Study Leads	Maria Pufulete, Ben Gibbison
PACES	Working Group	CSG3/4
	Study	Anticoagulation for New-Onset Post-Operative Atrial Fibrillation after CABG study
	Study Leads	Enoch Akowuah
PRIMARY	Working Group	CSG3/4
	Study	Transcatheter or Surgical Repair for Mitral Regurgitation
	Study Leads	Enoch Akowuah
TRICS IV	Working Group	CSG5
	Study	Liberal versus Restrictive Red Cell Transfusion in Younger Adults Undergoing Cardiac Surgery: The TRICS IV Trial
	Study Leads	Gavin Murphy
THERMIC IV	Working Group	CSG5
	Study	Normothermic versus hypothermic cardiopulmonary bypass in adult cardiac surgery: a multicentre feasibility randomised controlled trial
	Study Leads	CIRN
SLIMCARD	Working Group	CSG5
	Study	Preoperative weight management to improve outcomes of cardiac surgery in adults with obesity: A multicentre feasibility randomised control trial
	Study Leads	Gavin Murphy
NIHR PDG TARGET SSI	Working Group	CSG7
	Study	A Surgical Site Infection Risk Prediction Tool to Enable Targeted Infection Prevention Strategies in Adult Cardiac Surgery
	Study Leads	CIRN

Table 2: Projects successfully submitted to funding committee panels

BCIS4	Working Group	CSG1
	Study	A multicentre randomised trial of surgical versus percutaneous treatment of ischaemic heart failure in the United Kingdom, with embedded internal pilot and health economic analysis
	Study Leads	Mark Petrie, Gavin Murphy, Divaka Perera
ROMA WOMEN	Working Group	CSG1
	Study	Randomized comparison of the clinical Outcome of Single versus Multiple Arterial grafts in Women
	Study Leads	Mario Gaudino, Gavin Murphy, Mustafa Zakkar
PROTECT	Working Group	CSG3/4
	Study	A clinical trial to establish the optimum therapy which reduces thromboembolic complications without increasing bleeding risk after mitral valve repair surgery
	Study Leads	Enoch Akowuah
PROPHESY 2	Working Group	CSG5
	Study	A clinical trial to compare the efficacy, safety and cost-effectiveness of PCC versus FFP in the treatment of adult patients who develop bleeding within 24 hours of cardiac surgery
	Study Leads	Laura Green
HTA Platform Trial for AF	Working Group	CSG6
	Study	A Platform Trial for the prevention/Treatment of peri-operative Atrial Fibrillation
	Study Leads	Maria Pufulete, Ben Gibbison, Barbara Casadei

Surgical Mission or Sustainable Partnership?

Enoch Akowuah, Consultant Cardiac Surgeon, James Cook University Hospital, Middlesbrough

Joel Dunning, Consultant Thoracic Surgeon, James Cook University Hospital, Middlesbrough

Cristina Ruiz Segria, Surgical Care Practitioner, Cardiothoracic Department, James Cook University Hospital, Middlesbrough

Bhuvana Krishnamoorthy, Bhuvaneswari Bibleraaj, Tim Strang, Seth Vijayan, Nic Child, Richard Graham, Kim Thompson, Louise Houghton & Jill Malham

Surgical Missions to low-income countries are a perfect opportunity to provide surgical care to their most vulnerable and sick population who have no access to treatment. The cost for open heart surgery ranges from £8 to £20,000 and is frequently more expensive because most products are imported and subject to the vagaries of local tax regimes and changes in currency value. Consequently, most patients must request funds from non-governmental organisations and other sources. This delays assessment and treatment options, especially in congenital diseases. Although those missions perform an impressive number of surgeries in a very short period of time, they have a limited impact on long-term provision of care. On recent years, more surgical teams are adopting the model of 'Partnership', so a relation is developed over time between the foreign and the local teams, to maintain the number of surgeries and provision of care when the foreign team leave, based on Cape Town Declaration (2018).

Heart of Ghana' was created under those principals, to provide training and support to a foreign team to become independent. Cardiac surgeons and cardiologists can have access to specialised training abroad to acquire more complex skills and proficiency, however the rest of the wider team including nurses and perfusionists have no access to such opportunities. This approach requires a longer period of engagement and has the risk of well-trained professionals going to western countries looking for better professional opportunities. The key is to motivate, encourage and support the local team to develop excellent care services in their local hospitals to attend to their population in need.

Ghana is one of the leading countries in West Africa, with a population of 31 million. Like many other Sub-Saharan countries, it has a relatively young population with a high age dependency ratio of 66.7% showing the pressure of the overall economy to support and provide social services for youth and elderly people. Hypertension, rheumatic heart diseases, cardiomyopathy and congenital heart diseases are the main cardiovascular conditions in sub-Saharan Africa, contributing significantly to cardio-vascular morbidity and mortality. Cardiovascular heart diseases have increased in the last few years and contribute to high burden on health resources, plus the adoption of 'western' lifestyles has contributed to the

total cause of morbidity and mortality in adults in Ghana. Korle Bu Teaching Hospital has been the only centre providing care for patients with cardiovascular disorders and receive referrals from all over the country, however most patients who can afford to pay for their own surgery often prefer to fly out to India or other western countries for treatment.

Our first two trips took place at Kumasi, the second largest city of Ghana with a population of 3.4 million, in 2018 and 2019. A good relationship with local Cardiothoracic surgeon, Dr Isaac Okyere, was established prior to travelling with the mission lead surgeon, Professor Akowuah and supported by Dr Farkas an experienced cardiac surgeon and head of CardioStart International, a charitable organisation based in the USA. We performed several open-heart cases and pacemaker insertions and transformed an empty room into an ICU in the process.

Although the two missions in Kumasi were successful, several issues, in particular the covid 19 pandemic, interrupted the momentum gained by the team. At the same time, a new opportunity arose in Accra, the national capital, to open another unit. This new unit, led by Dr Baffoe Gyan, had the required staff, a brand-new surgical building and a very supportive management team who understood that cardiac surgery should be a priority for the population of Ghana.

The first trip to the new centre, University of Ghana Medical Centre, was in March 2022. Our aim was to meet the team and the institution and initiate the program by educating the key members of the new centre. These members include the Cardiac Surgeon, Anaesthetist, (the only Cardiothoracic Anaesthetist in Ghana), Scrub Nurses, who had some expertise in the other existing Hospital, and CITU nurses, who also had some exposure to cardiac surgery. The mission was successful and we decided not to lose the momentum and organise a second trip only six months later. The aim of our second trip was to consolidate previous knowledge and skills and provide as much training as possible to the staff, from nurses to junior doctors with special interest in imaging assessment (echo) and perioperative care after cardiac surgery. The trip was planned by Mr Joel Dunning and Professor Akowuah who organised several meetings attended by all members of the team to identify potential issues with the complex travelling due to COVID restrictions, putting together a sustainable team in Ghana with ward/ITU and theatre nurses, patients case load discussions, and equipment and consumables prior to the traveling date. A total of five major open-heart surgeries were performed, 159 percutaneous interventions, and over 40 echocardiograms include TOEs.

This time the local team were very well organised. The CITU nurses had everything all set up for the first patient, theatre staff had an impressive storage with all the consumables laid out in order and junior doctors had all patients' assessments with all relevant investigations for discussion. This was a huge difference from the first trip. Moreover, we learned that they had performed 10 open heart cases during the six months between the two trips. Our primary goal was achieved – they are working independently!

So what is next? More training, more positive rewards to the local team for their effort and hopefully more complex cases. It is clear that all missions face the same challenges over the years; more expensive consumables due to poor distributers, or not available to that part of the world, complex relationships between management and medical team, and 'brain drain' of well-trained professionals who leave to the private sector or to developed countries. We need a platform that will allow surgical teams around the world to share their experience and discuss common problems that can occur in any mission. This could help us to prepare the mission teams better and even have some tools to improve learning across all countries. Most importantly, we need to listen to the opinion of local teams regarding needs and ways of working, so we can get the most out of both teams. ■

Future perspectives: a student's reflection

Halil Ibrahim Bulut, Medical Student, Istanbul University Cerrahpasa Faculty of Medicine

As a medical student devoted to cardiac surgery since my first days of school, I spent an extraordinary internship at the Oxford Heart Center in the summer of 2022 under the supervision of Dr. Krasopoulos. I attended several magnificent procedures, from complex aortic surgeries to octogenarians who have undergone TAVR. Afterwards, when I returned to Istanbul, I continued shadowing in cardiac surgery. Nevertheless, despite the magic of surgery, there was always this question on my mind;

"Why don't the vast majority of surgeons who perform complex aortic surgeries, who perform heart surgery through incisions of a few centimeters, do transcatheter procedures that work 'wonders' for high-risk patients?"

When I asked this question, numerous senior surgeons stated that this should be done, but training is required. In addition, many aspiring cardiac surgeon medical students and cardiothoracic surgery residents want to keep up with the new era. Unfortunately, in the transcatheter age, many residency programs around the world do not actively provide transcatheter procedure training. And while post-residency fellowships are also insufficient in this respect, most of the transcatheter training programs affiliated with existing universities requiring the internal medicine board.

"In the age of the transcatheter, training is critical for future surgeons. While the training opportunities currently available are supported by the cardiothoracic surgery communities and industry. However, the residency programs need to support this as well."

A surgeon who has received transcatheter training and has mastered transcatheter procedures is extremely important for the heart team. Because both the prolonged lifespan and the early detection of symptoms make the management of structural heart patients a complex situation that can take years and includes both interventional and surgical procedures. That situation creates the need for interventional cardiac surgery.

With endless respect and thanks to Dr. Krasopoulos and his lovely team from the UK, Dr. Balkanay, Dr. Omeroglu, Dr. Alhan from Turkey, Dr.Tang, and Dr.Grubb from the US. ■

Reflections of a JCF

Najeeba Lallmahomed, Junior Clinical Fellow in Cardiac Surgery, St. Thomas' Hospital, London

"So, tomorrow morning send me a list of your top 20 reflections from our theatre session today," said my Consultant half-jokingly, as he first-assisted the ST8 performing a top-end. I nodded, my mesmerised face peeking over the anaesthetist's carefully placed drape, tiptoeing in my brand-new Crocs despite being perched on a platform, my 5'2 self stretching with all my might to see the rest of the operation.

I thought back to a few months ago, coming towards the end of FY2, desperately in love with Cardiothoracics but with no NTN to speak of. I asked my ST1 friend for advice: "Do you think I should take the JCF job?" "No", he said, "you'll be a ward SHO doing discharge summaries all day." Somehow, however, my gut was telling me this was the right decision, so I went for it.

Now nearly three months into the job, I am the happiest I have ever been. Not once have I felt like this was a non-training job (which it officially is). I am being allocated to theatres at least twice a week and I am already performing saphenous vein harvests independently after being trained by our brilliant SCPs. The ward is always so well-staffed with ANPs to guide and help me when the paperwork piles up and a designated ward reg is present every day. My mind is blown on a daily basis about how well-organised this department is. The nursing staff is ever so helpful which meant that three weeks in, an audit was already done and dusted by my very enthusiastic reg and me. My academic portfolio was growing healthily in this fruitful environment.

So Mr. B, my number one top reflection is, being a Junior Clinical Fellow in Cardiac Surgery is the best decision I have ever made. Yes, it is true I have to do a considerable number of discharge summaries, and the on-calls can be quite exhausting, but I am also getting to learn hands-on from watching and assisting the best surgeons in the country. So, to all FY2s out there who are interested in Cardiothoracics: if you are thinking of doing a JCF year, go for it. It will be enlightening, and by the end of it you will definitely get an answer as to whether or not this is the specialty for you: mine is in the affirmative. ■

Advanced Aortovascular Post-CCT Fellowship: Ionescu NTN Trainee Travelling Fellowship 2021

St Bartholomew's Hospital, London
St Orsola-Malpighi Hospital, Bologna

Damian Balmforth, Consultant Cardiac Surgeon, Royal Sussex County Hospital

Upon approaching the end of my higher surgical training I knew I wanted to gain further subspeciality training in complex aortic surgery. The aortic fellowship at St Bartholomew's Hospital was started in 2018 and came highly recommended by the three previous fellows. St Bartholomew's Hospital has one of the busiest aortic practices in the country dealing with all aspects of aortic surgery, from the root to the bifurcation via both open and endovascular techniques. For 12 months from September 2021, I worked primarily under the guidance of Professor Aung Oo, an inspirational surgeon and a great mentor.

During this fellowship, I was exposed to training opportunities that I had not previously thought possible. In a typical week, I would spend three to four days in surgery, with the majority being all day cases consisting of surgery to the proximal, arch and descending aorta. On Tuesdays we routinely performed a thoraco-abdominal aneurysm repair, most commonly extent II.

On other days, I scrubbed in numerous complex aortic operations. I performed 40 aortic operations as first operator consisting of 18 aortic root procedures (including valve sparing and redo procedures), and 19 arch/proximal DTA procedures (Hemiarch/Total arch/FET and AMDS devices). I made myself available to attend all aortic dissections and performed 12 type A aortic dissection repairs as first operator. I was trained in the full range of cannulation strategies with preferred routes being axillary, innominate or central cannulation via Seldinger or Samurai techniques.

In addition to aortic surgery I was also able to perform more routine cardiac cases throughout the year. I found that even in these cases there were opportunities for me to develop new skills. Coronary cases were performed off pump and isolated aortic valves were often done via hemi-sternotomy.

In addition to the operative experience, I became familiar with the perioperative management of the thoraco-abdominal patients and the unique challenges that this subset of patients provide. I ran the fortnightly complex aortovascular MDT meeting which helped to improve my decision making and interpretation of multi-modality imaging. There were also many opportunities to participate in and formulate new research projects within the department and I was able to present our work at the AATS Aortic Symposium in Boston in May.

In the last month of my fellowship, I travelled to the cardiac unit of Professor Davide Pacini at the St Orsola-Malpighi Hospital in Bologna. I observed Professor Pacini and his group of highly skilled surgeons performing the full range of surgeries from open aortic surgery to minimally-invasive mitral repair and endovascular aortic repair. As well as picking up many new operative tips, I was able to observe a completely different system of healthcare management and daily working practices. There was a great ethos of training at a much earlier career stage than I had observed in the UK, with trainees going straight into their chosen speciality from medical school. There was also a culture of dual consultant operating with all the surgeries I observed having at least two consultant surgeons at the table.

Bologna was a beautiful city to visit in the late summer and the department at St Orsola were extremely welcoming in showing me the sites of this historic city, particularly the many excellent pizzerias that my waistline is only just recovering from!

By the end of the fellowship I was able to perform root and partial arch replacement independent of supervision. The confidence that I gained from this has eased my transition into my new role as a locum consultant cardiac surgeon at the Royal Sussex County Hospital in Brighton.

The year that I spent as the aortic fellow at St Bartholomew's was undoubtably the hardest and most rewarding training period of my career. The volume of aortic work I was exposed to far exceeded my expectations and I was fortunate to be supported by amazing colleagues in both the consultant and registrar body, as well as the allied health professionals. There is a fantastic culture of training within the department and I met many individuals that will remain lifelong friends. I would like to thank Mr Ionescu for supporting my fellowship and Professor Oo for his mentorship throughout. ■

SCTS – Ionescu Nursing and Allied Health Professional Travelling Fellowship

Rosalie Magboo, Senior Sister, St Bartholomew's Hospital, Clinical Doctoral Research Fellow, Queen Mary University of London, SCTS Nursing and Allied Health Professional Research Lead

I was fortunate to be awarded with a prestigious SCTS-Ionescu Nursing and Allied Health Professional (NAHP) Travelling Scholarship to visit Canada in 2019. However, the COVID-19 pandemic intercepted and severely delayed my travelling. After almost three years of waiting, I finally completed my fellowship last summer hosted by Professor Suzanne Fredericks, a Full Professor in the Daphne Cockwell School of Nursing at Toronto Metropolitan University and an affiliate scientist at Toronto General Hospital Research Institute. The primary aim of the fellowship was to establish collaboration with international centres and universities to further develop my PhD programme of work, which focuses on determining the health-related quality of life (HRQoL) and psychosocial effects of the diagnosis and surgical interventions for aortovascular manifestations in Marfan syndrome (MFS) patients.

Marfan syndrome is a rare autosomal-dominant connective tissue disorder where approximately 80% will have a dilated aortic root by aged 40 years. Patients usually require life-long cardiac surveillance and live with the knowledge that they will require at least one major heart surgery in their lifetime. For these reasons, patients report MFS severely impacts on their daily lives and overall quality of life. However, there is a paucity of international evidence, and none in the UK populations, that explores the impact of HRQoL and psychosocial factors of living with MFS before and after cardiac surgery.

Through the fellowship, I had the opportunity to visit Toronto General Hospital to benchmark our practice on the care of MFS patients undergoing aortovascular surgery and meet several nursing experts in cardiac surgery and congenital heart disease. I also met with patients and relatives from various patients' organisations including the Aortic Dissection Canada and Genetic Aortic Disorders Association (GADA). From all these meetings, I was able to confirm that there is no existing clinical care pathway both in the UK and Canada that encompass the HRQoL and psychosocial aspects of care for the MFS. Despite this, I was able to build excellent networks for potential collaborative works in developing patient care pathway after my PhD.

During my visit, Professor Fredericks, whose program of research focuses on designing and evaluating interventions to support patients undergoing invasive surgical procedures, taught me on the different strategies that will build on and support my existing and future research projects. She facilitated reflective thinking and encouraged me to think about different ways to pursue my own personal growth and learning. One of the immediate projects that we planned of doing is the development of a psychosocial intervention based on the outcome of my PhD study. This will potentially open up opportunities for other nurses and allied professionals to embark on a doctoral study in both countries and encouraged them to pursue a clinical academic career. We also planned a four-paper series that will be commissioned by British Journal of Cardiac Nursing focusing on promoting collaboration between academia and clinical practice to generate research training.

Meanwhile, as a clinician and SCTS NAHP Research lead, I also took the opportunity to visit Dr Sheila O'Keefe-McCarthy, Associate Professor in the Faculty of Applied Health Sciences in the Department of Nursing at Brock University in Niagara, to collaborate and see their amazing work on 'translating research data into arts'. It is a creative and an innovative approach to data analysis and interpretation using arts to communicate research data. I was astonished on this unique approach of transforming data into understandable and relatable knowledge and information for use in clinical practice. It created meaningful education and knowledge mobilization through use of integrated arts-based approaches to research and learning. Dr O'Keefe-McCarthy has kindly agreed to join us in the upcoming NAHP University Research and Audit Day during the SCTS annual meeting in March 19-21, 2023 to share with us their spectacular work.

Dr O'Keefe-McCarthy, who is also the National Director of Research and Chair of the National Research Executive Committee of the Canadian Council of Cardiovascular Nurses (CCCN), kindly hosted a virtual networking events at Brock University participated in by researchers and clinical nurse specialists members of the CCCN from different parts of Canada. Together, we discussed the projects that the two organisations undertake and ways of supporting each other. There was a huge interest in supporting our Atrial Fibrillation (AF) Care Bundle Project, a national quality improvement project for the prevention of AF after cardiac surgery.

Overall, this fellowship offered a truly exciting opportunity. I was privileged to be mentored by clinical and academic experts in the field and was able to collaborate with high-calibre researchers to develop my post-doctoral work as well as our SCTS NAHP projects. I would like to express my sincere gratitude to SCTS and Mr Ionescu for this amazing experience. ■

SCTS Ionescu Medical Student Fellowship – The Papworth Experience

Denis Ajdarpasic, Graduate Entry Medical Student, University of Nottingham

Firstly, I am very grateful for the generosity of Mr Ionescu and SCTS for an immersive experience that gave me a fantastic insight into the career of a cardiothoracic surgeon.

On the back of a very challenging period for the medical profession post-pandemic, I wasn't sure how much hands-on experience was possible, but Mr Nashef and colleagues were very supportive and accommodating throughout my four weeks at Royal Papworth Hospital.

The key principle that will stay with me is the importance of teamwork, not just in providing care for patients, but how a supportive atmosphere is essential when it comes to mentoring junior staff through balancing on-the-job teaching with opportunities to apply those lessons in practice. The entire surgical team were keen to teach and got me involved with vein harvesting (figure 1), assisting with coronary artery bypass graft procedures (figure 2) and sternotomy closure (figure 3). Each member of the MDT contributed a unique perspective that underpins the collaborative nature of cardiothoracic surgery.

My average week would include a mixture of theatre time, clinics, ward-based tasks and attending multi-disciplinary team meetings. The emergency cases were both exciting and eye-opening, but also showed me the reality of the fast paced and unpredictable nature of being a cardiothoracic surgeon.

Figure 4: A Heart in Glass by Angela Palmer. Ink drawing on glass sheets based on MRI scans on display at Royal Papworth

Figure 5: Exploring the beautiful sights in my free time, Queen's College

I am indebted to the brilliant team at Papworth for making this placement possible and would encourage medical students to immerse themselves during similar placements to appreciate the hidden skills of collaborating within an MDT that is rarely taught at medical school. ■

Figure 2: Assisting with a coronary artery bypass graft procedure

Figure 3: Performing sternal wound closure

Figure 1: Assisting with short saphenous vein harvesting

SCTS–Ionescu Non–NTN Surgical Fellowship 2020 Advanced Coronary and Structural Heart Fellowship

Ottawa Heart Institute, Canada

Saqib Qureshi, Cardiothoracic Surgery Medical Practitioner, City Hospital Nottingham

I was fortunate enough to receive the SCTS-Ionescu Non-NTN Surgical fellowship 2020 and visited the Ottawa Heart Institute in Canada. Although the paperwork to go on fellowship can take a year to be approved, there is no need for Canadian medical exams if one has the FRCS examination.

The Ottawa Heart Institute runs diverse programmes ranging from Minimally Invasive and Structural Heart to Transplant and is one of the best institutions in cardiovascular research in North America. Fellows are expected not only to carry out clinical duties, but also to pursue productive research themes and deliver at least two publications by the end of their fellowship.

The rotations are hectic, with 1-3 to 1-5 on calls, which are non-resident, but the OR opportunities are well balanced between Residents and Fellows. A typical day can be very long starting from 6 am with morning rounds, theatre briefing at 7:30 am, the first case is usually ready by 9 am, the second case by 3 pm with a usual finish of 8 or 9 pm. In the OR there is plenty of hands-on training under supervision of the staff surgeon, depending on individual level of experience. Most staff are very keen and push to take fellows from point A to the next point in their skill set.

My personal interest was minimally invasive coronary and robotic surgery and I was fortunate enough to work closely with Dr Marc Ruel, Chief of Division and leader in Multi Vessel Small Thoracotomy (MVST) and Robotic coronary surgery. There was enough exposure to learn the tricks with setup, exposure, conduit harvest and target grafting. My other interest was structural heart, and had considerable hands-on training on MitraClip device. This has a long learning curve, but the dedicated training was worth it. ■

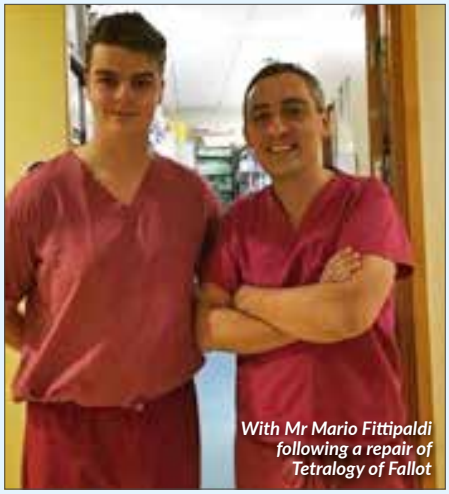
Crossing the Welsh border for Paediatric Cardiac Surgery

Alexander Reynolds, Medical Student, Swansea University Medical School

Privilege is a buzzword in modern medicine. I'm privileged, if for no other reason than I was born in the UK and born healthy. I was about to find out what the value of the latter meant for some.

Meeting sick children and their families as they were admitted to the regional centre has been my most recent privilege. The emphasis on detail, theoretical knowledge and routine was drilled into me. "You need to study!" was the continuous advice from one enthusiastic senior fellow. And study I did. I studied the tenacity of waiting for haemostasis before closing after many hours of operating. I studied the value of honesty during parental consultation. I studied despair when the worst of outcomes occurred, and a new family's light went out. I studied what textbooks do not teach.

With Professor Massimo Caputo, following a repair of Tetralogy of Fallot



With Mr Mario Fittipaldi following a repair of Tetralogy of Fallot

In Wales, around 300 children per year are born with congenital heart disease. Many will cross the border to access surgery. They are not privileged in this respect. One young patient suffered a community arrest and was rushed across the border for the prospect of ECMO. They made it to Bristol; but died shortly after. Had they have been privileged in living closer to England, I bet my career they would have made it onto ECMO.

There can be no pain greater than outgrowing your own child. The power to prevent this misery for others could become my ultimate privilege. ■

Post CCT Fellowship in Advanced Aortic Surgery and Transcatheter Aortic Valve Implantation at Toronto General Hospital

Stuart Grant, NTN trainee and Academic Clinical Lecturer, University of Manchester

Arranging the Fellowship

Toronto General Hospital has enjoyed an enviable history of academic achievement and clinical success in cardiovascular surgery and was an obvious choice for gaining further experience in a post CCT fellowship. I approached the fellowship director around 18 months before I planned to start the fellowship and would recommend making contact early as there is a waiting list and a considerable amount of paperwork to complete. The application was previously a written process, however now prospective fellows are expected to interview. Although my primary motivation for the fellowship was to gain further experience in complex aortic surgery, the opportunity to be actively involved in the TAVI programme was highly attractive.

The fellowship

The work schedule is intense and involves covering the operating rooms, the ward and the intensive care unit. In my case, I also covered between one and two TAVI lists per month. The education programme is excellent with rounds, journal club or heart team meetings scheduled before clinical commitments every day. Although some fellows, such as myself, are there on specific fellowships, each fellow is involved in the whole spectrum of adult cardiac surgery including transplantation and adult congenital surgery. In my role as an academic clinical lecturer I had academic time available and the department is very research active with plenty of scope for fellows to get involved with or initiate research projects. Fellows are also able to attend one conference or academic meeting.

TAVI

I was the first surgical TAVI fellow at TGH with all previous fellows being cardiology trainees. I had previous experience in performing both trans-femoral and surgical access TAVI and this was highly beneficial for hitting the ground running. TAVI at TGH is performed jointly between the cardiologists and the cardiac surgeons. The TAVI team are excellent and work very well together. It is a highly efficient programme with five scheduled cases on each list and the surgeon and cardiologist rotating as lead clinician. The fellow would perform all of the cases unless there were technical issues and I would often work with one of the other cardiology TAVI fellows.

Aortic Surgery

The aortic programme at TGH is very busy and would receive complex aortic referrals from across Ontario and Canada. It is led by Dr Maral Ouzounian and Dr Jennifer Chung. I worked with one of the other fellows in the aortic team and between us

we would take part in all major aortic cases. This amounted to between two major aortic cases per week. Cases included aortic dissections, thoracoabdominal aortic surgery, valve sparing root surgery, aortic arch surgery, adult Ross procedures and TEVARs. Along with the aortic team, I attended both the Houston Aortic symposium and the AATS meeting.

Life experience

I was fortunate to be able to bring my wife and two daughters to Toronto. The city is exciting and multi-cultural with very friendly people. It is a good base to go for day trips or explore other parts of North America. The winter is particularly cold and got down below -20°C on occasion, but the summer is warm and pleasant. As a family we were able to visit Niagara Falls, Quebec, Ottawa and St John. We were also able to watch the Toronto Raptors, Maple Leafs and Blue Jays.

The fellowship was a fantastic experience both clinically and personally. I would highly recommend it to others interested in aortic surgery and TAVI. I have learnt a considerable amount and look forward to putting this into practice as I take up my consultant post at James Cook University Hospital. I wish to thank the SCTS for the opportunity and support. ■

SCTS-Ionescu Team Travelling Fellowship: Leeds Multidisciplinary Congenital Cardiac Team Visit to Toronto 4 – 8 July 2022

Carin van Doorn, Senior Consultant Congenital Cardiac Surgeon, Recipient of Team Travel Fellowship, Leeds Teaching Hospitals NHS Trust

The UK has one of the best outcomes for the treatment of congenital heart disease in the world. However, these results may not be sustainable as there is a lack of interest from trainees in the speciality, senior surgeons are leaving to work abroad, there are problems with team working, and there is a lack of innovation. In May 2021, the Congenital Cardiac Team of the Leeds Teaching Hospitals was therefore delighted to be awarded the SCTS-Ionescu Team travelling fellowship to visit the congenital cardiac programme at Sick Kids in Toronto and its associated adult congenital cardiac programme at Toronto General Hospital. Importantly, the Canadian programme also works in a national health service setting, and we were keen to learn what this long-established programme of excellence could offer us. An added advantage was that the new Chief of Cardiac Surgery, David Barron, previously worked in the UK (Birmingham) and this provided a unique opportunity to get an even better understanding of the similarities and differences between the Canadian and UK systems. The aim of the visit was to look at clinical outcomes, efficiency, and sustainability of the services.

After a year's delay due to COVID, we were finally ready to travel to Canada in July 22, and were the first outside visitors to Sick Kids since the start of the pandemic. Our multidisciplinary team* consisted of seven consultants and three nurses, covering paediatric and adult congenital heart disease, and included both recently appointed staff as well as senior members.

As flight costs had skyrocketed since the fellowship was awarded, direct flights from London had to be changed to a more affordable option and we flew Ryanair from Leeds, Bradford Airport to Dublin and from there on with AirCanada to Toronto. As it was the summer season the hotel accommodation was changed to more budget friendly student apartments, which turned out to be very clean, portered and within easy walking distance of Sick Kids.

In preparation for our visit, we had to enrol in an 'e-learning onboarding program' for each of the two hospitals and the teaching included IT security, and fire risks.

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In addition, there were the necessary visa and COVID related processes. To help plan the program for the visit, a remote meeting with Toronto took place in June and we prepared a short video to introduce ourselves, our service, and the questions that we would like to explore. Unfortunately, just before departure for Toronto two of our team, Fiona Willcoxson and Carol Bodlani, tested COVID positive and there was no other option than to leave them in the UK – but flights were rebooked for a future visit.

During our visit in Toronto many of the COVID measures were still in place, and very similar to those in Leeds. We were made extremely welcome. After a short introduction for the whole team, we went to our various specialist areas and as the week progressed, further contacts found and explored. As observers we were given access to the clinical areas, labs, and many departmental meetings. As many of the latter were still on-line, it was also possible to invite those that had to stay in the UK. Over dinner at night, the experiences of the day were exchanged, and plans made for the days ahead.

We were all struck by how well run the departments were, both with regards to the clinical service delivery as well as the very strong culture of consultant lead teaching, training, and research.

On-line meetings started on time, were disciplined, and those present were aware of their role and had prepared for the meeting. This was particularly apparent in the joint clinical conferences with excellent case presentations by senior fellows. Subsequent showing of the imaging was without IT hick-ups, and relevant studies had been pre-selected and were accompanied by expert commentary explaining the important findings. We were also impressed by the weekly Performance Meetings during which activity and complications were reviewed. Apart from the well-established Toronto departmental audit database and contributions to the North American congenital cardiac audit, the department is also developing a model for measuring performance across the individual patient pathway. Discussions during these meetings were open, honest, and respectful with the aim to continue to improve the patient pathway at every level.

The congenital cardiac service is practiced across two sites, paediatrics at Sick Kids and adult congenital at the Toronto General Hospital. The hospitals are in very close proximity to each other and connected by an underground tunnel for easy travel during the winter. There is a dedicated cardiology team at each site, but the surgeons treat both children and adults, as well as collaborate with the adult aortic team. This is a similar setup to many Units in the UK. Maternity services are on a different site, but again very close, although for the occasional high risk delivery advance planning for early postnatal intervention remains necessary.

The Leeds team outside Sick Kids in Toronto (from left to right) Daniel Valesco-Sanchez, Giuseppe Pella, James Oliver, Joanne Birkett, Carin van Doorn, Celia McKenzie, Sarah Everett, Davinder Singh

The spectrum of disease that is treated is not dissimilar from ours (apart from transplantation). However, an important difference is the focus on consultant led teaching and research in every area of the service. In the operating theatres, this resulted in longer anaesthetic times, but there did not appear to be a time pressure for risk of cancellation of the second case. Observations and medicine use were recorded on an on-line system that then continued to be used on ICU and the wards. The progress of the surgical procedure could be viewed via intra-operative camera projections on a wall-mounted screen. No-one was playing on their phone and theatre staff was pro-active in getting things ready. The number of staff in theatre appeared to be less than we were used to, and the same observation was made in the catheter lab. However, as ancillary services (such as sterilisation) are on-site, the system runs more efficient. We were informed that recruitment and retention of staff are on-going problems with staff needing to do overtime when required.

Cardiac patients are admitted on a general PICU but looked after by a separate Cardiac ICU team. Care is not protocol driven but the whole team will continuously look for opportunities to move the patient forward. The widespread use of intra-operative local blocks facilitates early extubation. Chest closures are done without need to call the theatre team and chest drains and pacing wires removed as soon as possible. There is a multidisciplinary morning ward round and a 'PICU consultant of the week' and the latter is very busy on the floor driving the system forward. A cardiology and a surgical fellow are also actively involved in PICU 24 hrs/day. The Unit has a strong culture of mutual support and WhatsApp is used to call for help when needed. There are subspeciality teams for common cardiac conditions, such as heart failure and single ventricle circulations.

Congenital Heart Disease is (one of the) flagship specialities of Sick Kids and the medical staff and administration are highly aware of this and dedicated to continuously enhance this reputation. The hospital attracts external donor funding to support its cardiac department. Despite recruitment and retention problems there was a sense that cancellation was only acceptable as a last resort.

Importantly, clinicians did not have to spend significant amounts of their time to try and secure operating slots or ICU beds. Consultant staffing levels appeared better than in the UK and active involvement in teaching and training was the norm. We were welcomed by many consultants who generously gave their time to discuss their clinical practice, research, and training. Examples of training included the weekly in-house teaching program for surgical residents who also have access to an on-site skills lab, to practice operations on 3-D printed heart models. Clinical simulation training is extensively used on the PICU. The Cardiac Unit runs many in-house as well as external courses, and many consultants and senior fellows contribute to this. Academic activity is also an important part of the consultant role. Consultants, including all four surgeons, have a special area of research interest, and many have dedicated lab space in the nearby basic science building. The hospital attracts many fellows from all over the globe and these are assigned research projects as part of their training program. Fellows play an important role in the day to day running of the department.

The nursing structure is different from the NHS in that there is no routine integration of nursing and medical staff in meetings. The nursing meetings run separately, but in the same efficient way as the medical ones, and there is early decision making about capacity and sending for patients.

The extended role of the nurse, such as that of advanced clinical nurse specialist, or specialist nursing roles in transition or learning disability, does not exist. However, there are nurse run clinics. Particularly in the outpatient clinic, there is an emphasis on trying to avoid unnecessary hospital admissions with dedicated rooms for ambulatory treatment of patients.

After a very interesting week in the hospital and a quick trip up the CN tower, we left with many new impressions. A thorough debrief of the visit took place whilst waiting at the airport. Long flight delays meant that we nearly missed our connection in Dublin, but we just made in time to catch the flight to Leeds with all – but one – of the suitcases present.

In summary, we were impressed by the focus on education, research, and continuous quality improvement that was deeply embedded in the Toronto practice, and which was an integral part of the daily workplan for all medical and nursing staff. Despite challenges in workforce, a collaborative and disciplined approach ensured that every effort was made to avoid cancellation. In the UK, the focus of medical and nursing staff is increasingly diverted to service delivery and education and research are seen by many as an optional extra in the daily work plan. However, not only do high cancellation rates continue to exist, there also is a failure of the current workforce to transfer their skills, knowledge and passion for their specialties to the next generation.

We wish to thank the staff from Sick Kids and the Toronto General Hospital, and particularly prof David Barron, for their time and effort during the visit. We are very grateful to the SCTS and Mr Ionescu for fellowship that enabled us to make the visit. We have started to put some of the learning in our daily practice and aim to continue to collaborate with our contacts in Toronto. A Unit away day is planned for next January to discuss the learnings of the visit in more detail and incorporate these in the development plan for the coming years. ■

***Team members Congenital Cardiac Unit Leeds Teaching Hospitals NHS Trust**

- **Carin van Doorn**, Senior Consultant Congenital Cardiac Surgeon, Recipient of Team Travel Fellowship
- **Giuseppe Pelella**, Consultant Congenital Cardiac Surgeon
- **James Oliver**, Consultant Consultant Adult Congenital Cardiologist, Lead Clinician Congenital Cardiology
- **Fiona Willcoxson**, Consultant Paediatric Cardiologist, Clinical Lead for Congenital Cardiac Network Yorkshire & the Humber
- **Daniel Valesco Sanchez**, Consultant Interventional Cardiologist
- **Davinder Singh**, Consultant Paediatric Intensivist
- **Bulelwa (Carol) Bodlani**, Consultant Paediatric Cardiac Anaesthesist
- **Celia McKenzie**, Deputy Head of Nursing, Leeds Children's Hospital
- **Joanna Birkett**, Adult Congenital Heart Disease Nurse Specialist
- **Sarah Everett**, Deputy Team Leader Cardiac Theatres

Obituary: Professor Marc de Leval MD 16/04/1941 – 26/06/2022

David Anderson, Congenital Cardiac Surgeon (retired)
Victor Tsang, Consultant Congenital Cardiac Surgeon, Great Ormand Street Hospital for Children
Andrew Parry, Consultant Congenital Cardiac Surgeon, Bristol Royal Infirmary

The Society for Cardiothoracic Surgery in Great Britain and Ireland mourn the death of Professor Marc de Leval, acknowledged as one of the "Greats" of congenital cardiac surgery, not only in the UK but world-wide. It is a challenge to do justice to Marc's contribution given the sheer magnitude of his achievements.

Born in Belgium, he graduated in 1966 and embarked on a career in surgery. He first encountered cardiac surgery when he attended a lecture by Charles Dubost and was immediately captivated. He applied to Dr Frank Gerbode for a training opportunity and there gained experience in the speciality. After two years in San Francisco he was appointed senior registrar at Great Ormond Street Hospital. While there he was awarded the prestigious Ewarts Graham travelling fellowship which enabled him to return to the USA to enhance his training under Dwight McGoon. Within two years his qualities were evident, and he was appointed consultant to GOSH in 1974 where he remained for the rest of his career.

Marc was a very hard-working surgeon amassing a huge personal operative experience. However, as well as being an excellent operator he was a thinker and innovator. Of his many innovations three stand out.

1. He pioneered the development of the Modified Blalock-Taussig Shunt (in which a prosthetic graft is interposed between the subclavian and the PA) between 1975 and 1979 reporting on 99 operations in 1981. This is now the universally employed technique and the classical shunt is virtually extinct.

2. For those children born with defects that result in a "single functional ventricle" the current endpoint is the Fontan operation, first performed in 1968. The original operation (using the right atrium as a contracting conduit) developed a bad reputation and many modifications were introduced to try to overcome the failings. Marc's research, using casts of various Fontan connections and lycopodium powder, demonstrated that rather than help forward flow, atrial contraction introduced turbulence and thus energy loss which inhibited flow. This resulted in the development of the "Lateral Tunnel Fontan" and later the "Extra-cardiac Fontan" techniques used today with excellent medium term results.

3. Though a gifted surgical technician who undertook the full spectrum of congenital heart disease, like all surgeons he had poor outcomes from time to time. However, unlike many surgeons who seek to blame others at such times Marc looked at himself first.

In the late 1980s the arterial switch operation was becoming established as the best operation for transposition of the great arteries (TGA). Marc introduced the switch to GOSH but although initial results of the first 52 cases were excellent, over the next 20 cases he had a cluster of deaths. He immediately looked at himself as the cause and knowing that another surgeon in the UK had consistently excellent results sought re-training. His results returned to their previous level and remained excellent. Reflecting on this personal experience, Marc remarkably wrote a paper about this experience which was presented at the American Association of Thoracic Surgery (AATS) in 1993. This was regarded by many as the most important surgical paper of the decade.

Following this paper, Marc pursued his interest in human error seeking ideas from the airline industry and Formula 1 motor racing, and in 1994, in collaboration with Professor James Reason of Manchester University, he set up a study entitled "Human factors and cardiac surgery" using the arterial switch as the study operation. The study, presented at the AATS in 1999 and published in 2000 concluded that minor errors which might be thought to be insignificant had a cumulative effect and their elimination was key to better outcomes.

These two publications are a small but very important part of the 300+ publications that Marc was involved with throughout his career. In 2011, he was awarded the "Scientific Achievement Award" from the AATS and in 2019 a Lifetime Achievement Award" from the SCTS.

In 1983, collaborating with his surgical colleague Dr J Stark, they wrote a textbook "Surgery for congenital heart disease" now in its third edition.

In 2019, he published his autobiographical account of a lifetime in Children's heart surgery entitled "Humanity and Humility". Marc was everything the title of his biography says; human, humane and humble. He treated everyone with courtesy and never displayed a hint of pomposity or self-aggrandisement. He was a modest man and did not glory in the title of professor being content to be called Marc.

He retired from active surgery at GOSH in 2006 but remained as an emeritus consultant making his wisdom and experience freely available to all. He also actively supported the charity "Chain of Hope" established by Sir Magdi Yacoub OM.

Outside cardiac surgery he was a very active member of the RAC club where most mornings he started his day with a swim. He also had a love of Porsche cars (left-hand drive), probably reflecting his European heritage.

In retirement he faced cardiac surgery personally having his aortic valve replaced in 2008. Around this time, he was stricken by Parkinson's disease which he bore with the courage and the dignity that characterised his professional life.

Lord Brock, a pioneer cardiac surgeon and President of the Royal College of Surgeons, defined a surgeon as a doctor who performs operations as opposed to a simple operator. By that criteria Marc was certainly a surgeon.

He leaves his wife and two daughters, several grandchildren, and a huge "family" of children and adults who owe their lives and health to his surgical skills and research throughout his career. To his trainees and all professional colleagues who met him he leaves a standard of professional and personal conduct that should be our ambition to match.

It should be the aim of everyone to eventually leave the world a better place as a consequence of the life we lived. In that respect Marc over-achieved. ■

New appointments September 2021 to January 2023 ...

Name	Hospital	Specialty/Role	Starting Date
Mr Vamsidhar Dronavalli	Freeman Hospital, Newcastle	Consultant Cardiac & Transplant Surgeon	January 2022
Mr Izanee Mydin	Freeman Hospital, Newcastle	Consultant Cardiac & Transplant Surgeon	January 2022
Mr Antonios Kourliouros	John Radcliffe Hospital, Oxford	Consultant Cardiac Surgeon	April 2022
Mr Michail Koutentakis	University Hospital of Wales	Consultant Cardiac Surgeon	July 2022
Miss Elaine Teh	St James's University Hospital, Leeds	Consultant Thoracic Surgeon	August 2022
Mr Joshil Lodhia	St James's University Hospital, Leeds	Consultant Thoracic Surgeon	August 2022
Mr Amit Modi	Southampton General Hospital	Consultant Adult Cardiac Surgeon	September 2022
Mr Priyad Ariyaratnam	Derriford Hospital, Plymouth	Consultant Thoracic Surgeon	October 2022
Mr Faruk Ozalp	Freeman Hospital, Newcastle	Locum Consultant Cardiac & Transplant Surgeon	October 2021
Mr Fabio Falconieri	Morriston Hospital, Swansea	Locum Consultant Adult Cardiac Surgeon	July 2022
Mr Anthony Chambers	Royal Infirmary of Edinburgh	Locum Consultant Thoracic Surgeon	August 2022
Mr Piergiorgio Solli	Royal Papworth Hospital, Cambridge	Locum Consultant Thoracic Surgeon	August 2022
Mr Periklis Perikleous	Bristol Royal Infirmary	Locum Consultant Thoracic Surgeon	September 2022
Miss Priya Sastry	John Radcliffe Hospital, Oxford	Locum Consultant Cardiac Surgeon	September 2022
Ms Katie O'Sullivan	University Hospital of Wales	Locum Consultant Cardiac Surgeon	September 2022
Mr Damian Balmforth	Royal Sussex County Hospital, Brighton	Locum Consultant Cardiac Surgeon	October 2022

Demitted roles

Thank you to the following for the time and commitment they gave to their roles ...

Role	Name
SCTS President	Simon Kendall
SCTS President-elect	Narain Moorjani
SCTS Associate Meeting Secretary	Sunil Bhudia
SCTS Education Secretary	Carol Tan
SCTS Education Thoracic Surgical Tutor	Elizabeth Belcher
SCTS Audit Chair	Douglas West

New roles Congratulations to the following ...

Role	Name
SCTS President	Narain Moorjani
SCTS President-elect	Aman Coonar (from AGM 2023)
SCTS Executive Elected Trustee	Attilio Lotto (from AGM 2023)
SCTS Executive Elected Trustee	Karen Redmond (from AGM 2023)
SCTS Deputy Meeting Secretary	Sunil Bhudia
SCTS Associate Meeting Secretary	Carol Tan
SCTS Education Secretary	Elizabeth Belcher
SCTS Education Thoracic Surgical Tutor	Michael Shackcloth
SCTS Audit Co-Chair	Uday Trivedi
SCTS Deputy Adult Cardiac Surgery Audit Lead	Dimitrios Pousios
SCTS Deputy Thoracic Surgery Audit Lead	Nathan Burnside
SCTS Perfusion Representative	Mubarak Chaudhry

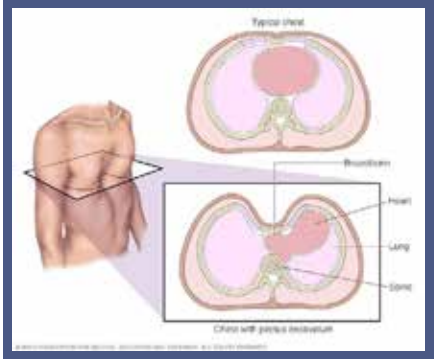
THURSDAY
2ND FEBRUARY 2023

11:30 – 15:30

BEST PRACTICE FOR PECTUS

Royal College of Surgeons, College Library, 1st Floor, 38-43 Lincoln's Inn Fields, London, WC2A 3PE

WE ARE HOLDING THIS EVENT TO RELEASE EVIDENCE BASED GUIDELINES FOR BEST PRACTICE FOR PECTUS



We invite patients / parents to attend this event but colleagues involved in the surgery / care of such patients are most welcome to register

Please register here or scan the QR code below:

www.scts.org

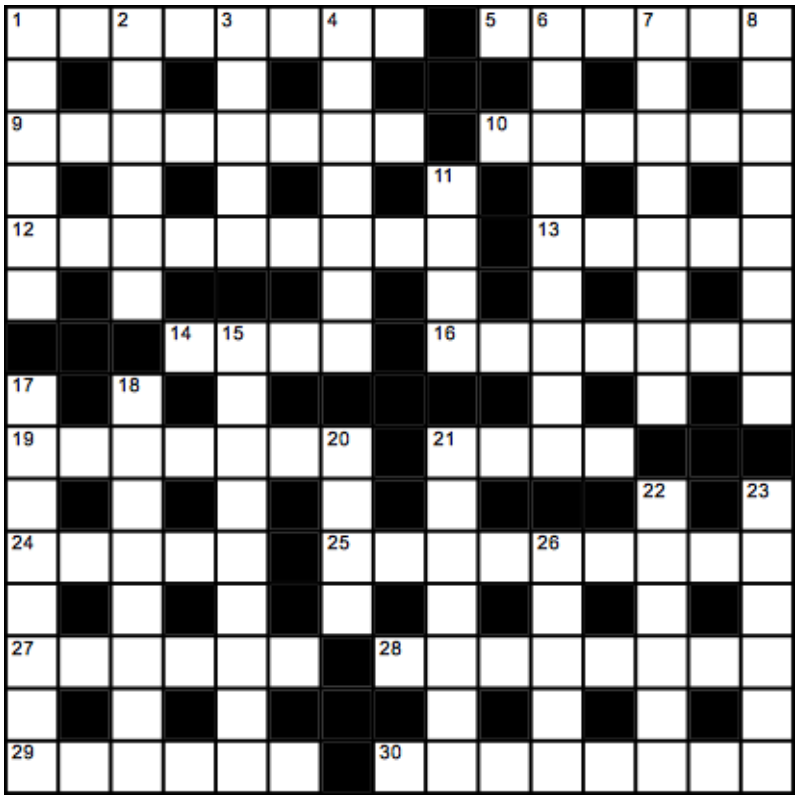
PROGRAMME

11:30	Welcome and Register
12:00 – 12:45	Sandwich Lunch
12:45 – 12:55	1. What is the condition - reasons for deformity, range of deformities – *Mr Ian Hunt, St George's*
12:55 – 13:15	2. Patient stories 2a Physiological Challenges 2b Psychological Challenges
13:15 – 13:30	3. History of intervention and different interventions available – *Professor Babu Naidu, Birmingham and Mr Sean Marven, Sheffield*
13:30 – 13:50	4. Evidence for efficacy/ benefits and also define the risks – *Professor Dawn Jaroszewski MD Mayo Clinic USA*
13:50 – 14:10	5. Patent stories of going through surgery and if there were any benefits 5a Physiological benefit 5b Psychological benefit
14:10 – 14:40	6. Why and How Scotland and Wales offer surgery 6a *Miss Malgorzata Kornaszewska, Cardiff* 6b *Mr Carl Davis, Glasgow* 6c *Ms Ashley Johnstone, Physiotherapy, Support and Rehabilitation, Glasgow*
14:40 – 14:50	7. Proposed NHSE strategy – Spec Comm speaker
14:50 – 15:00	8. Best Practice for Pectus Paper - and desire for Centres of Excellence, National Database, agreed criteria, review outcomes – *Mr Joel Dunning, Middlesbrough*
15:00 – 15:10	9. Closing remarks – *Patient spokesperson and RCS Eng President*
15:10 – 15:30	10. Time for media interviews / questions / discussion

Society for Cardiothoracic Surgery in Great Britain and Ireland
38-43 Lincoln's Inn Fields, London WC2A 3PE | 0207 869 6893

Crossword

Set by Samer Nashef

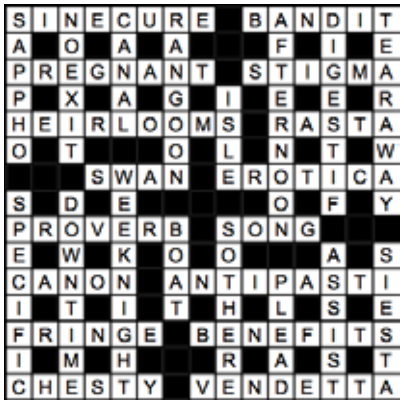


Please email solutions by 31/03/23 to:

emma@scts.org ***or send to Emma Piotrowski, SCTS, 35-43, Lincoln's Inn Fields, London WC2A 3PE***

The winner will be randomly selected from successful solutions and will win either a bottle of 'fizz' or fine olive oil.

Congratulations to Jonathan Hyde for winning the August 2022 Bulletin crossword competition (right) who chose a handmade ceramic bottle of olive oil as his prize.



Across

1 Monk(ey) (8)
5 Keep quiet about warm coat (6)
9 Ultimately cod as well as other fish shedding scales (8)
10 String instrument returned without charge (6)
12 Unfairly segregate seasonal fare (6, 3)
13 Diet drug in top drawer? (5)
14 Symbolic figure, motherless northerner (4)
16 The man's into clone reproduction in class (7)
19 Sweet and affectionate worker (7)
21 See 3 Down
24 Freeze alloy with metals to make time capsule (3, 2)
25 Once more appear sure about farce, perhaps (9)
27 Hang up mirror section, backing challenge (6)
28 The odds on Janis and idiot perhaps to break up (8)
29 Support from artificial intelligence (6)
30 Piece in newspaper about Steptoe and son (8)

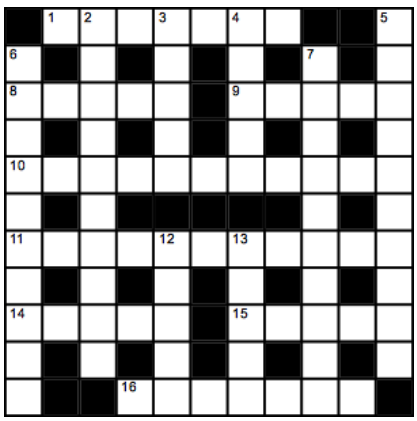
Down

1 Couple of doctors briefly coming up to see the old man (6)
2 Fine perhaps, a bit like some wordplay on the radio? (6)
3/21A Gather ye rosebuds for another mad recipe (5, 4)
4 Modulate and polllute? (7)
6 Mustang's tool may be a lucky thing (9)
7 Hall isn't built to provide accommodation for colonies (8)
8 Eats greens? We hear they're no longer effective (3-5)
11 Leading optician gets labelled 'Eagle Eye' (4)
15 Pretend agony in speech bubbles (9)
17 Proper tripe eating here in Paris (8)
18 Nip back after funds were stripped to give support (8)
20 Bird in the afternoon (4)
21 Record of tramp embracing setter (7)
22 Local innocent embraces tango (6)
23 Fly like Michael Jackson said (4, 2)
26 Alter dance again? (5)

Sudoku

		4					3	
	1				9			
5			7	3				
	3				4	8		
6						3	1	
	7		9			2		5
	8				2			
4		1	6		7			
		6	3					7

Quick Crossword



Across

1 Place to eat (7)
8 Exclusive (5)
9 Bird droppings (5)
10 Explained (11)
11 Baby specialty (11)
14 Old anaesthetic (5)
15 Flavour (5)
16 Word with the same meaning (7)

Down

2 Punctuation mark abused by greengrocers (10)
3 Heavy drinker (5)
4 Keen (5)
5 A, B, AB and O (5, 5)
6 Task (10)
7 In a guarded manner (10)
12 Range (5)
13 Surpass (5)

AstraZeneca

AstraZeneca are pleased to confirm they will be supporting

SCTS 2023

Sunday 19th - Tuesday 21st March at ICC Birmingham

JOIN US

at the AstraZeneca Funded Promotional Symposia on Sunday 19th March 12:30-13:30 where we will discuss advances in treatment of early-stage NSCLC

GB-40875 | December 2022

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*No clinical data are available that evaluate the long-term impact of RESILIA tissue in patients.

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