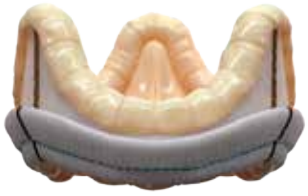
Issue 18
August 2025

the bulletin

Society for Cardiothoracic Surgery in Great Britain and Ireland

EPIC™ PLUS SUPRA
THE IDEAL VALVE OPTION FOR LIFETIME MANAGEMENT

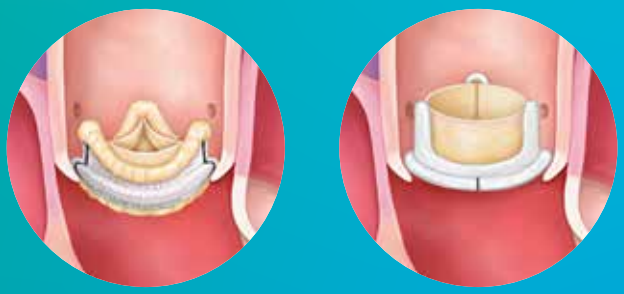


No other valve has been expertly engineered with non-curtaining leaflets,* a low overall profile, and fracture-friendly stent with future interventions in mind.

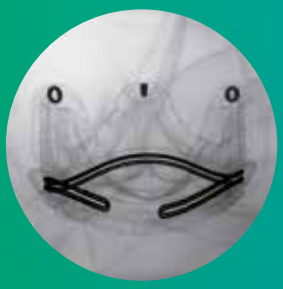
EPIC LEAFLETS DO NOT CURTAIN

Curtaining is a characteristic of pericardial leaflets where the leaflets form a curtain between stent posts that may present coronary obstruction risk (see right) or interaction with common suture affixation method.[1] In contrast, the leaflets of the Epic Plus Supra do not curtain and can mitigate coronary obstruction risk post-TAV-in-SAV.

For illustrative purposes only.
TAVI frame used is not meant to depict any specific valve.



Epic Plus Supra leaflet behavior vs. Inspiris‡



- Epic Plus Supra fractures at low pressures (8 atm)[2]
- Low profile stent posts[3]
- C-shape radiographic profile designed to facilitate expansion for future ViV

VALVE-IN-VALVE** SUCCESS[4]

>95%

Freedom From Valve Intervention 3-Years Post ViV

* Based on Abbott internal testing.
** The safety and effectiveness of valve-in-valve procedures in Epic Plus and Epic Plus Supra valves has not been established.

REFERENCES: 1. Technical report. Data on file at Abbott. 2. Allen, KB., Chhatriwalla, A., Cohen, DJ., et al. Bioprosthetic valve fracture to facilitate transcatheter valve-in-valve implantation. Ann Thorac Surg. 2017;104:1501-1508. 3. Epic Plus IFU 4. Fang, K. et al (2022, June) Three-year outcomes of Valve-in-valve intervention within the Epic™ Supra and Epic™ Mitral valves in a Medicare population. Poster presented at the TVT Annual meeting, Chicago.

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the bulletin
Society for Cardiothoracic Surgery in Great Britain and Ireland

In this issue ...

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APROTININ *10,000 KIU/ml Injection BP*

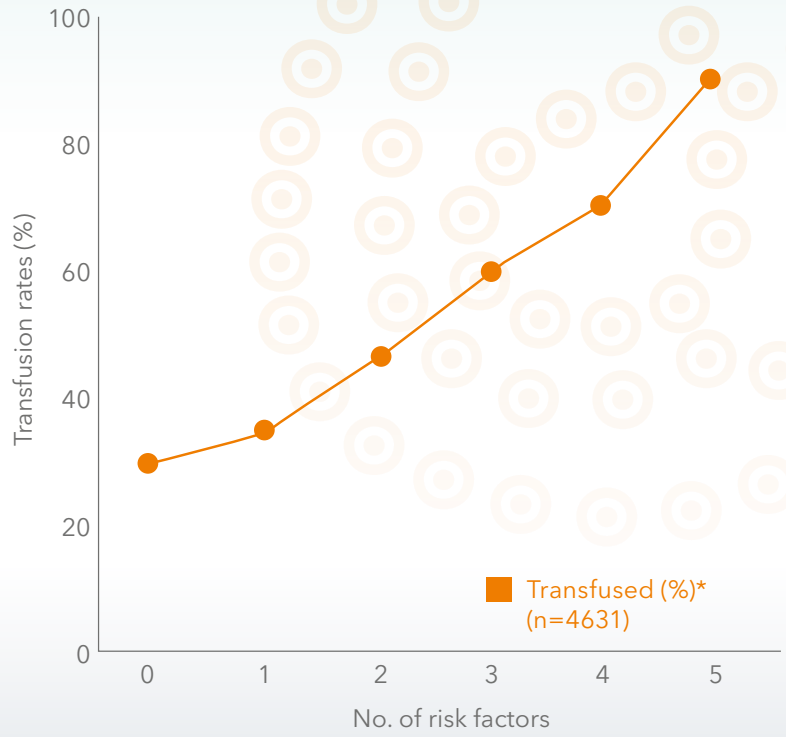
Aprotinin is indicated for prophylactic use to reduce blood loss and blood transfusion in adult patients at high risk of major blood loss undergoing isolated cardiopulmonary bypass graft surgery. Aprotinin should only be used after careful consideration of the benefits and risks, and consideration that alternative treatments are available.[1]

Scan this QR code for aprotinin prescribing and adverse event reporting information

Red blood cell transfusion is the single factor most reliably associated with increased risk of post-operative morbidity and mortaility[2]

- Blood loss requiring transfusion remains a risk in cardiac surgery, despite the use of blood-sparing agents and blood management techniques[3-5]
- The graph below shows how multiple patient risk factors compound to increase the risk of transfusions during CABG surgery[6,7]

Risk Factors for Tranfusion in iCABG Patients:



In a study of patients undergoing scheduled coronary artery surgery, a set of pre-defined risk factors were applied.[6]

- Age >70 years
- Female
- Low molecular weight heparin or antiplatelet therapy <5 days pre-operatively
- Estimated Glomerular Filtration Rate <60mL/min
- Insulin dependent diabetes mellitus

Regardless of volume of blood loss, when patient risk factors are compounded, transfusion rates increase[6]

Scan the QR code or visit our website at aprotinin.co.uk to see what other HCPs think of aprotinin and for other useful resources

Adapted from Myles PS *et al.* 2017[1,2]
*Any transfusion up until hospital discharge

References:
1. Aprotinin 10,000 KIU/ml Injection BP Summary of Product Characteristics. Available at www.medicines.org.uk. Accessed November 2024.
2. Koch C *et al.* Crit Care Med 2006 Vol. 34, No. 6; 1608-1616.
3. Mehran R *et al.* Standardized Bleeding Definitions for Cardiovascular Clinical Trial. A Consensus Report From the Bleeding Academic Research Consortium. Circulation 2011;123:2736–2747.
4. Stevens LM *et al.* Major transfusions remain frequent despite the generalized use of tranexamic acid: an audit of 3322 patients undergoing cardiac surgery. Transfusion 2016;56:1857-65.
5. Gombotz H *et al.* The second Austrian benchmark study for blood use in elective surgery: results and practice change. Transfusion 2014;54:2646-57
6. Myles PS *et al.* Tranexamic Acid in Patients Undergoing Coronary-Artery Surgery. N Engl J Med 2017;376:136-48.
7. Supplement to: Myles PS *et al.* Tranexamic Acid in Patients Undergoing Coronary-Artery Surgery. N Engl J Med 2017;376:136-48.

NORDIC PHARMA

UK-TRA-2500002 | February 2025

From the Editor

Dionisios Stavroulias, Publishing Secretary, SCTS

What constitutes a good editorial? If it were only about summarising and organising colleagues' communications, then yes, AI could do the job. But I hope my editorials do not read like automated bullet points. It is my belief that we, as human beings, long for *direct experience*. We look for the *personal flavour* in a text. We enjoy a-different-than-ours-opinion more than a piece of dry information. Why? Because we are all joined, in so many levels of our lives. Being members of our great cardiothoracic society is only part of our common destiny.

In his classic masterpiece "The Great Philosophers", Bryan Magee expands on Heidegger's key idea: we humans are not subjects-spectators, separated by an invisible plate-glass window from the world of objects in which we find ourselves. We are not detached from some external reality which is "out there". On the contrary, *we are part and parcel of it all*, and from the very beginning, we are in amongst it all, *being in it*, coping with it. This is the same concept that modern quantum mechanics proposes about our entangling relationship with our surrounding environment, and we find it already, many centuries ago, in the "Atman" of Hinduism, in the African "Ubuntu", and in the "Being" of Parmenides.

Aman Coonar's first "The President's article," is true to his personal style, so familiar within his weekly *From the President's Desk* updates. Aman shares his journey to becoming a leading figure in our society. The five pillars he outlines for strengthening our society are ambitious yet of paramount importance: financial resilience; a stronger public and political voice; launching *Friends of SCTS* to amplify patient stories and raise our profile; reinforcing our digital presence; and enhancing governance.

I really enjoyed reading Rana's final report as Honorary Secretary; it was my favourite part of this edition. The way he tells his story made me feel like I was watching a film unfold, following the inspiring journey of a cardiothoracic surgeon from his early days to becoming a senior consultant. It was both moving and memorable. I am delighted to see him take on his new role as SCTS Representative on the Royal College of Surgeons (RCS) of England Council.

Turning now to education, I would like to congratulate Elizabeth Belcher, on her appointment as Chair of the Intercollegiate Examinations Board in Cardiothoracic Surgery. Elizabeth's energy, determination and vision have been at the heart of some of our society's most important educational developments. From the creation of the SCTS–RCS Edinburgh-accredited post-CCT Fellowships to improving access to SCTS Education for Trust Appointed Doctors, has made a real difference to many. I wish her every success in her new role.

Manoj Kuduvalli informs us how SCTS has been asked to work with NHSE, the Vascular, and Cardiology societies to develop a national pathway for the elective management of chronic aortic dissection. The initiative will also cover identifying at-risk individuals (including family screening) and managing incidental aortic aneurysms detected, for example, via Targeted Lung Health Check CT scans.

On a similar subject, Riccardo Abbasciano illustrates the DECIDE TAD initiative, an ambitious approach to Thoracic Aortic Disease (TAD) which promotes targeted screening for patients and their at-risk relatives. The programme integrates genotype-driven risk assessment to guide earlier and individualised interventions. In my view, this personalised and preventive care represents a major advance in the management of aortic disease.

Karen Redmond's report for thoracic surgery showcases the comprehensive working groups within thoracic surgery. These include Babu Naidu with the Thoracic Surgery Priority Setting Partnership, shaping the future of thoracic surgery research for years to come; Kandadai Rammohan and Nathan Burnside developing an SCTS thoracic database with Dendrite; Doug West and the rollout of NCIP; and the Trauma Working Group with multispecialty best practice guidance for the management of patients with blunt chest trauma. The long-awaited ORIF trial results are expected to be integrated into future care pathways. Finally, the RESTORE trial has completed recruitment, with results expected in late 2026. I am pleased to see pectus patients' needs and concerns are finally receiving the attention they deserve.

The National Trainee Committee for Cardiothoracic Surgery (NTCCTS) representatives, Ali Ansaripour and Mohamed Sherif's account remind us of the 2025 workforce report which presents a compelling forecast: nearly 60 new consultant positions are projected to be advertised in the coming years, alongside 80 anticipated retirements across the specialty. This marks a profound shift within the consultant workforce and accentuates the critical imperative to equip our trainees with the skills and experience necessary to compete successfully for these roles.

To complement the broader perspective on the future of surgical training, Narain Moorjani's final report as the SCTS representative to the RCS England Council, highlights critical issues that require urgent attention (see the "Future of Surgical Training"). These include service provision at the expense of training, limited access to training in theatre, the absence of allocated time for teaching within job plans and the significant financial burden of training on resident surgeons. We must take proactive steps to develop pragmatic responses to these challenges, safeguarding the quality and sustainability of surgical training. I would like to thank Narain for this important part of his outstanding contribution to the College and the SCTS.

There's so much more to discover in this edition of *the bulletin*. As we embrace new technologies and innovations, a final invitation, kindly borrowed from Tim Mitchell*, President of RCS England: "It is critical that we do not lose sight of the needs of the patient (and even the surgeon) to interact with another human being, the need to be listened to and the need to be valued. As we harness the benefits of new technology, we must not forget the patient in the room." The latest edition of *Good Surgical Practice* is essential reading for all of us.

Please send any comments to my email: **dionisios.stavroulias@ouh.nhs.uk** ■

*From his latest article, Bulletin of the Royal College of Surgeons of England

From the President

Aman Coonar, SCTS President, Consultant Thoracic Surgeon, Royal Papworth Hospital, Cambridge

It is an honour to write my first article for the SCTS Bulletin as President of our distinguished Society. This edition is full of thoughtful and uplifting contributions from across our community. From clinical innovation to education and personal reflection, *the bulletin* shows the remarkable breadth and spirit of our membership. Thank you to everyone who contributed. Your work informs, connects and strengthens us.

Special thanks to Editor Dionisios Stavroulias, Society Administrator Emma Piotrowski, and the rest of *the bulletin* editorial team. They have worked hard to raise standards and impact. Every article is reviewed and selected, not automatically accepted, and the result is a publication of substance, value and wide interest.

Thanks and New Beginnings

I want to thank those who have served in leadership and helped guide the Society to where we are today. In particular, I thank Rana Sayeed, who has stepped down as Honorary Secretary. We have been friends for 20 years since we were fellows together in Toronto. His attention to detail, integrity and experience have been invaluable. We are fortunate that Rana will go onto to serve as SCTS representative to the Royal College of Surgeons of England.

I would like to thank Mark Jones for his ongoing work as Treasurer and Sri Rathinam as Communication Secretary, and all the committee leads and members. Thanks to Sunil Bhudia our meeting secretary. He is as energetic as ever, already well into preparation for our next annual meeting in Belfast on March 15th-17th 2026. Save the date!

I am delighted to welcome our new apex team. President-Elect Enoch Akowuah has been fully engaged from the outset, as we bring our strengths and sector expertise together. His clarity, wise and thoughtful leadership is a great asset. Doug West, our new Honorary Secretary, brings a wealth of experience in thoracic surgery, audit and advocacy. They are different, brilliant and committed to building forward together.

We are enjoying the easy working and friendship of this group.

On the Shoulders of Others

I am grateful to Simon Kendall and Narain Moorjani, the two Presidents I have known best. Simon supported me as a trustee and encouraged me to take on leadership of the thoracic committee. My predecessor, Narain built on this work and successfully led a wide platform of meaningful initiatives. I now have the privilege of continuing that journey.

Our Annual Meeting in Edinburgh, was the largest ever. The energy from delegates was striking. A highlight was hearing the world-beating Sir Clive Woodward speak about "teamship". His message was clear and relevant: team members may hold different views and skills, but ultimately must act with unity and common purpose.

A Personal Path

I went to Guy's & St Thomas' Medical School, then UMDS, now part of King's College London. My clinical tutor was the thoracic surgeon Jules Dussek who was later SCTS president. I was his student, SHO and registrar. He had high standards, a broad surgical scope, and a flair for humour, cooking, and sailing. His influence was formative and remains with me.

After training in London under many wonderful consultants, I undertook senior fellowships at the Toronto General Hospital in advanced thoracic surgery and lung transplantation. That institution taught me more about surgery, gold-standards and innovation. I continue to draw on those lessons.

Principles in Action

I was elected on a platform that included holding high advocacy, openness, work-life balance and clinical standards. As a new consultant, I had been surprised to hear whispers about the lack of interest in cardiothoracic surgery! I took up that challenge in setting up SCTS Students (later INSINC) to fill our tank with young energy and ability. With respect to clinical leadership, I have been involved in the actual delivery of new clinical pathways and the commissioning of national services. Our community came together to make that all happen, and there is more to come. To answer the question "What does SCTS do?", we have tried to make our dealings more open in the form of the *From the President's Desk* series. With respect to work-life balance, the first change was moving our senior leadership team meetings from 7.30 pm to 4.00 pm. This shift mattered. It makes space for people with caring responsibilities and supports a culture of better balance. Our leadership still remains largely middle-aged and male, but we must change that. So put yourself forward. We welcome applications from those who bring fresh perspectives and different experiences.

At a national level, we face serious healthcare challenges. We spend similar amounts per person as some peer countries, yet outcomes and patient experiences are often poorer. Our clinical voice must be louder. In addition

to operative excellence, one of our jobs is to design patient-centred pathways, and we must embrace that opportunity. The role of the administration is then to enable and support those pathways under our guidance.

The government has laid out three pillars for NHS reform: from analogue to digital, from (treatment for) sickness to prevention, and from hospital to community. These align with our vision for cardiothoracic surgery. Our growing expertise in minimal access techniques, fast-track anaesthesia and enhanced recovery shows how this can be done. We must continue to lead the way with dialogue, safely and at scale.

Clinical Initiatives

Thoracic surgery must continue to evolve. The Society will support the development of a national thoracic database and a major NHS service improvement initiative, the VERITAS project: Very Enhanced Recovery in Thoracic Anaesthesia and Surgery. This programme will formalise best practice, promote innovation and help units deliver better outcomes with shorter stays and safer recovery. The data supports this, and the system will see huge savings in hospital occupancy. Delivery is about teamship and the right culture.

We also recognise the unique needs of congenital cardiothoracic surgery. This is a highly specialised community within our Society with distinct training, service and workforce requirements. We will continue to support and ensure they are fully represented in national discussions.

In cardiac surgery we must support wider adoption of minimally invasive techniques and enhanced recovery. As in thoracic surgery, culture is as important as technology. If we believe that patients can go home sooner after surgery, and the evidence supports it, that belief can drive change. We must bring the whole team and patients with us. We are linking with partners such as the British & Irish Society for Minimally Invasive Cardiac Surgery (BISMICS), the Association for Cardiothoracic Anaesthesia & Critical Care (ACTACC) and Industry to deliver on that.

In transplantation, we must face up to the reality of our activity and results as compared to the best international outcomes. Where we lead, let us propagate that; where we do not, let us aim to improve. Separating heart and lung transplant programmes, with teams focused on each, may achieve better results. SCTS can help to design better clinical pathways, and then it is for the administration to allocate the resources effectively. We already spend a great deal on this. Are patients and society getting value?

"It is an honour to write my first article for the SCTS Bulletin as President of our distinguished Society. This edition is full of thoughtful and uplifting contributions from across our community. From clinical innovation to education and personal reflection, *the bulletin* shows the remarkable breadth and spirit of our membership."

Strengthening Our Society

We need to make the Society stronger and more sustainable. That means:

- Financial resilience through industry support, philanthropy and fundraising
- Stronger advocacy with a louder public and political voice
- Launching *Friends of SCTS* to amplify patient stories and raise our profile
- Making our digital presence stronger
- Enhancing governance, including the potential appointment of a part-time Chief Operating Officer or Charity Secretary

These are not just internal matters. They are how we develop, protect and project the society so we can achieve our mission.

Supporting and Preparing

We must look after our members and units. That means ever better systems for mentoring and support, particularly when colleagues or units face personal or professional difficulty. Recovery and reconciliation really matter. Compassion is not optional. I will quote from our president-elect who described it as "putting our arms around our members".

We live in uncertain times with the drums of wars beating. The last few decades have seen a decline in national resilience, with creaky hospitals, leaking pipes, potholed roads, late trains and falling morale. The COVID-19 pandemic exposed the cracks in our supply chains, national infrastructure and emergency response. We must be prepared for war, pandemics and natural disasters. This means we must hold reserves of essential materials and make time for training and planning for the emergency response. If there is a crisis, our healthcare systems will be stretched, and we may need to care for casualties and maintain our elective services as best we can.

A Shared Mission

Whether you are a patient, student, trainee, consultant, nurse, perfusionist, anaesthetist, allied professional or in management, we invite you to be part of the SCTS mission. Speak up. Write. Mentor. Lead. Innovate. Question. Contribute. All of us have something valuable to bring.

The future of cardiothoracic surgery is bright. With open minds, balanced lives and patients at our centre, we will continue to build something remarkable for our people. ■

Welcome to the SCTS Annual Meeting... 1997!

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

Recently, I was asked to clear my office – in a good way, to accommodate a new addition to our department – and I found a memento of my first interaction with the Society: the programme and abstract book for the 1997 Society of Cardiothoracic Surgeons of Great Britain & Ireland Annual Meeting which I attended as a Senior House Officer. The Society held this three-day event at the Royal College of Surgeons, Dublin, as a joint meeting with the Society of Perfusionists under the auspices of David Wheatley, SCTS President.

The abstract book gave an unexpected reminder of times past: how meetings used to run, the changes (and ongoing controversies) in clinical practice, and former colleagues and mentors. What has changed over the last (almost) three decades besides the name of our Society?

There were only two parallel streams on the second day, with adult cardiac and thoracic sessions interspersed with basic science and transplantation. Helpfully, the book details the 'telephone and fax number for people wishing to leave messages' and advises that 'messages will be posted on a notice board near Registration'.

The clinical and scientific content of the presentations ranged from techniques from a bygone era to topics that remain current today. A randomised trial of open versus closed mitral valvotomy concluded that there was 'evidence in favour of balloon mitral valvotomy'; balloon mitral valvotomy (or percutaneous mitral commissurotomy) has become the Class I recommendation for severe mitral stenosis. PET scan in the evaluation of thoracic tumours was a state-of-the-art presentation at the turn of the century, heralding the role of PET-CT in evaluating thoracic malignancy. There were numerous presentations on off-pump CABG, radial artery harvesting, and arterial revascularisation. The topic of the opening debate titled Evidence-based medicine – the death knell of innovation in cardiothoracic surgery remains a current concern, but a later presentation on partial left ventriculectomy (the Batista operation) is a warning against innovation without clinical evidence. And the authors of Complete data collection in thoracic surgery – an achievable goal will be pleased that plans and funding for the SCTS Thoracic Registry have finally been agreed!

There have been substantial changes in our Annual Meeting and clinical practice since 1997. Donald Ross delivered the Honoured Guest Lecture on a journey through cardiothoracic surgery – the early years. What would his successor say about the specialty's middle age?

What I recall most about the meeting is not the venue or the presentations, but the presenters and authors and their impact on me and my career as trainers, mentors, colleagues, and friends. The registrar who encouraged me to apply for my first post in the specialty. The consultant who encouraged me with the words 'My kind of surgeon, Mr Sayeed!' as he plucked a blonde hair (my wife's, actually) from my pristine suit at a pre-interview meeting. The trainer who took me through my first case only three months before the 1997 meeting and their consultant and registrar colleagues who patiently guided me through my registrar training. The consultants who appointed me to my current consultant post for whom I would become Clinical Lead.

There are less favourable memories too…the consultant who sneered at my CV during feedback after my first (unsuccessful) registrar interview, the senior figure who raised the accuracy of trainees' CVs at the Annual Meeting only weeks after my successful consultant appointment, and a few other challenging encounters.

All of us have the opportunity to encourage, cheer, support, guide and mentor those around us – junior, contemporary, and even senior – within surgery and its allied disciplines across many areas – the clinical workplace, the Society, and anywhere clinicians meet. What memories will your name evoke in 30 years?

New senior appointments

There have been several new senior appointments within the SCTS Executive and its sub-committees.

Babu Naidu has been appointed SCTS Research Thoracic Co-Chair to succeed Eric Lim. The Society has appointed Cha Rajakaruna (cardiac) and Giuseppe Aresu (thoracic) as its first Fundraising Leads to help secure public donations and industry funding to support its educational, patient advocacy, and other activities.

Outside the Society, we congratulate Elizabeth Belcher on her appointment as Chair of the Intercollegiate Examinations Board overseeing the intercollegiate exam in cardiothoracic surgery leading to the award of the FRCS(C-Th), succeeding Sri Rathinam. Mike Shackcloth replaces her as Thoracic Education Secretary.

Finally, Doug West was appointed as Honorary Secretary Elect in April and succeeded me as Honorary Secretary after the SCTS Executive meeting in June. I have joined the Council of the Royal College of Surgeons of England as SCTS representative.

I wish our new appointments every success in advancing the work of the SCTS and strengthening the specialty. ■

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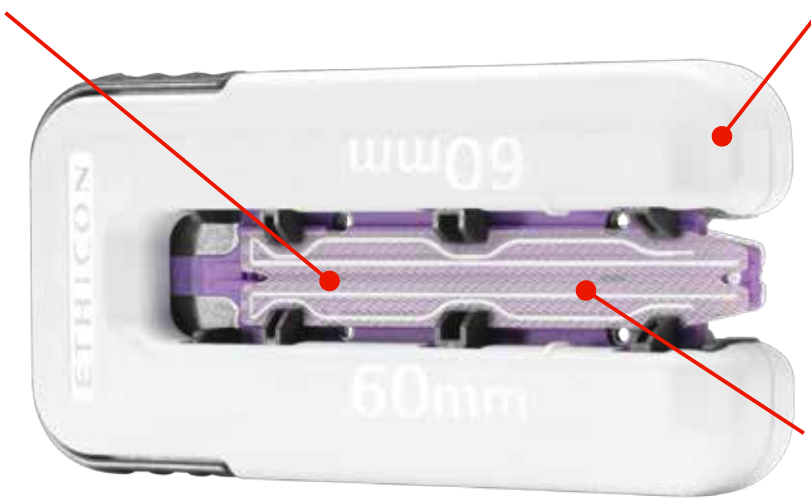

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SCTS Meetings Report

Making Cardiothoracic Surgery Great

Nisha Bhudia, SCTS NAHP Meeting Lead, Lead Pharmacist, Critical Care and Anaesthesia, Royal Brompton and Harefield Hospitals

Sunil Bhudia, SCTS Meeting Secretary, Consultant Cardiac Surgeon, Royal Brompton and Harefield Hospitals

Trainee wet lab on Sunday 17th March

The SCTS Annual Meeting 2025 was in the Edinburgh International Conference Centre from 16th to 18th March 2025 in the historic and cultural city of Edinburgh. The meeting had a real buzz from beginning to the end of meeting with over 1,500 registrations. Most delegates attended all three days with some taking advantage of single- and two-day registrations.

In keeping with previous years, the University Day on the Sunday was very well attended with lecture-based sessions from national and international experts, generating healthy debates from some of the foremost experts within their fields.

The NAHP University Day saw a record number of delegates attending the lecture-based sessions on Research Equity, Translating Research into Practice, post-operative complications following CT surgery and Training and Development for Future Surgical Care Practitioners.

Medical students aspiring to become cardiothoracic surgeons were welcomed with first-hand talks on life as a thoracic surgeon, cardiac surgeon, congenital cardiac surgeon, and cardiothoracic trainee and had the opportunity to ask questions about any aspect of cardiothoracic surgery. They presented high-quality abstracts, competing for the Pat Magee prize.

Thoracic Surgery University highlighted Quality Improvement as well as Contemporary Management of Lung cancer and Pleural disease. The Cardiac Surgery University Day had sessions on Aorta as an organ, Mitral Valve and Aortic Valve, Alternatives in Cardioplegia, and Cardiothoracic Transplantation.

Focused wet lab sessions for trainees was introduced at University Day with great support from consultants, trainees, and industry. Trainees had the opportunity to practice coronary artery bypass grafting, aortic valve and mitral valve procedures with consultants on hand for guidance. Wet lab training was extended into a session on Ross procedure with experts from congenital and adult cardiac surgery providing technical tips on this procedure. The NAHP wet-lab and dry sessions ran before and after lunch with informal teaching for all.

This year seven lunch-box sessions took place with great educational content and were well attended. The exhibition hall was very well supported and filled by our partners, giving delegates the opportunity to meet and network with them. The Meetings Team would like to extend our gratitude to all industry partners who have continued to support the SCTS meeting.

Exhibition hall, EICC

Sir Clive Woodward presenting on "Teamship"

This year saw more collaboration with other societies. Representatives from the European Association for Cardio-Thoracic Surgery attended the meeting with a stall in the exhibition hall and will be reciprocating the same for SCTS during their next annual meeting. CTSNet will continue to showcase some of the University Day lectures on their website and highlight the SCTS to the wider cardiothoracic community.

On Monday 17th March we kicked off the Presidential Plenary with a thought provoking and inspirational talk by the former Head Coach of England rugby union team and World Cup Winner, Sir Clive Woodward on "Teamship" followed by Narain Moorjani's Presidential address. The theme of Leadership in Surgery was addressed in the second plenary by true leaders in their field. Peter Hutchison spoke on achieving change through global surgery, Isabelle Schmitt-Opitz gave a European perspective, and Rowan Parks spoke on the Royal College of Surgeons' perspective. This great session culminated with The Tudor Edwards Lecture titled A Simple Gift by Yolonda Colson, former President of American Association for Thoracic Surgery. All highlighted what a positive difference vision and true leadership can make, and Yolonda Colson reminded us about the beginnings of and close relationship between SCTS and AATS.

Whilst Luca Vricella from Chicago, USA, was a guest speaker in the Congenital abstract session, the NAHP parallel sessions explored NAHP-led Services. This year the NAHP team introduced an interactive session on Escape the Coffin led by senior cardiothoracic trainees.

There were also many smaller meetings dedicated to research trials, including FARSTER-Care, RESTORE, AFFECT and THERMIC trials. This year, James Lind Alliance Priority Setting Partnership for thoracic surgery took place.

On Tuesday 18th March, the third plenary entitled Looking into the Future, saw Andrew Stevenson give a talk on the Future of Sustainable Surgery, Lawrence Tallon provided an insight into the Future of the National Health Service and Nigel Tai brought together Lessons learnt from Military Surgery and the Future of Surgical Practice. Finally, Shafi Ahmed opened our minds to the Future of Surgical Education demonstrating the possibility of virtual medical schools.

The Heart Research UK sponsored lecture was delivered by well-deserved Gebrine El Khoury titled Aortic Valve Repair – The Art and Science of Preservation.

Across Monday and Tuesday, the abstract driven scientific sessions and quick-fire moderated poster sessions showcased the best national and international abstracts. Delegates were able to rate presentations on the interactive SCTS 2025 App. Markings to select the prize winners will be a weighted combination of the programme committee marks, app review and ranking performed by chairpersons who moderated the sessions.

Various sub-committees held meetings during these three days and Women in Cardiothoracic Surgery took that a step further with a networking event during the coffee break on Monday.

As the programme has become busier, we recognise the importance of down-time and allocating areas to relax. Pet therapy was made available during lunch breaks on Monday and Tuesday, giving many the opportunity to benefit from the calming atmosphere of therapy dogs and their cuddles. Huge thanks to Mel Hughes from Therapet, who organised a team of volunteers and their dogs to come in.

This year's social event included our traditional Pub Quiz which had very competitive participants, and The Gala Dinner on Monday evening at the spectacular National Museum of Scotland. Guests were piped into the venue by a bagpiper, where there was a re-enactment from the Clan Warriors during the welcome reception. The bagpiper then led guests up the stairs to the Grand Gallery to watch an address to the haggis by the President, before being served a 3-course Scottish meal. Following the awards ceremony, entertainment from 'Whisky Kiss', a ceilidh band with a modern twist, got everyone up on to the dancefloor for Scottish dancing. It was a night to remember! ■

Save the date – SCTS Annual Meeting 2026 – 15th – 17th March, ICC Belfast


Carol Tan with a volunteer from Therapet


National Museum of Scotland, Grand Gallery

SCTS EXECUTIVE COMMITTEE

President: Aman Coonar

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Regional Deputy Adult Cardiac Surgery Leads:
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Branko Mimic

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Rosalie Magboo

Co-opted Member:
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TBC

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Transplant Surgery Lead:
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TBC

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Ali Ansaripour

Trainee Representative:
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Mohammad Hawari (Thoracic)

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Shilajit Ghosh (Thoracic)

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Communication Lead:
Vivek Srivastava

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Babu Naidu

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Sunil Bhudia

Adult Cardiac Surgery:
Gianluca Lucchese

Thoracic Surgery:
Babu Naidu

Congenital Cardiac Surgery:
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Zainab Khanbhai
Hemangi Chavan
Nisha Bhudia

Trainee Representative:
TBC

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Gokul Raj Krishna

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(Cardiothoracic SSL)
Babu Naidu
Luke Rogers (aSSL)
Ricky Vaja (aSSL)
Akshay Patel (aSSL)
Jacie Law (aSSL)
Ann Cheng (aSSL)
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Hind Elhassan (aSSL)

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Appointed Member:
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Ahmed Abbas
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Aswani Pillai
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Executive Co-Chair:
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Trainee CT Surgery Rep (Wales):
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Trainee CT Surgery Rep (England):
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Fathima Mubarak
Kudzayi Kutywayo
Bhuvaneswari Krishnamoorthy
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SCTS

Annual Meeting 2026

ICC Belfast
15–17 March

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SCTS Nurses and Allied Health Professional Update

**Amanda Walthew, SCTS Nursing and AHP Chair,
Lead Advanced Clinical Practitioner, Liverpool Heart and Chest NHS Foundation Trust**

What a great success this year's annual meeting was! I must thank the NAHP leaders, and all others involved for their dedication and hard work in the planning and organisation. Look out for their update in the SCTS annual meeting summary.

Nursing and Allied Health Professionals are a rapidly growing group within our SCTS family, who play a vital role in the delivery of high-quality patient care. This year we had many nominations for the annual awards. It is so important to share why the winning teams were chosen. They all had tangible positive outcomes, such as demonstrable improvements in patient care or in the effectiveness of service provision and vitally innovative projects which make a difference and can be replicated.
The winners are as follows.

Cardiac team of the year

Cardiac nurse and allied health professional team, St Bartholomew's

*Rosalie Magboo, Cheryl Uy, Kristia Basilio
Senior sisters in ICU*

The team at St Bartholomew's utilised a multidisciplinary approach to surgical site infection management. This has led to a significant reduction in infection rates,10% in 2019 and a further 4% by 2024. They use a 10-step strategy to manage SSI's;
1. Barts surgical assessment tool, 2. Surgical wound care plan. 3. Correct dressing directed by SSI risk tool. 4. Correct use of SSI algorithm. 5. Appropriate timing of antibiotic prophylaxis. 6. Sternal support usage.
7. Octenesan wash. 8. Gentamycin impregnated collagen matrix/ moderate to high-risk patients.
9. Tight blood glucose control. 10. Photos at discharge. This excellent project was chosen due to the transferability nationally.

Thoracic team of the year

Harefield Thoracic advanced practitioner team

The thoracic ANP Team at Harefield Hospital exemplifies the values of innovation, patient focus, and collaborative excellence. Through their initiatives, the team has enhanced patient outcomes and service efficiency and set a new standard for post-operative care. Initiatives include a successful nurse led chest drain service, electronic microbiology screening protocols and a referral pathway facilitating patient management post transfer. Their commitment to advancing the field of cardiothoracic surgery and their unyielding passion for quality patient care is the reason they were chosen for this award, recognising their exceptional contributions to healthcare innovation and leadership.

Excellence for innovation in practice

Surgical cardiac specialist nurse team, Basildon

Jade Theisinger, cardiac surgical CNS, Essex Cardiothoracic Centre

The team at Basildon have utilised a virtual ward for cardiac and thoracic patients facilitating earlier discharge and surveillance of patients resulting in reduced length of stay and huge cost savings. It is well documented that staying in hospital for prolonged periods is detrimental to patients' health and wellbeing, causing deconditioning, increasing risk of infection and thromboembolism and mental health impact. This initiative has been wholeheartedly embraced by the team and has this has shown a definitive positive improvement in patient care. They are proactively and dynamically connecting with patients using a wide variety of media

sources and they are actively promoting and engaging with patients and their families to improve care and experience.

Inspirational star
Nisha Nair, SCP, St Thomas' Hospital

Nisha Nair

Nisha's journey is marked by her dedication to empowering others. Colleagues commend her ability to inspire and motivate, emphasising her role in fostering a culture of excellence. Her passion for her work and her focus on positive impact exemplify her commitment to the field and to those she mentors. Her story encourages future practitioners to pursue excellence while supporting their peers. In summary, Nisha exemplifies the qualities of an outstanding Surgical Care Practitioner.

Spotlight

Cardiac Update
Ana Alves, Cardiac NAHP lead
Ana and her team at Guy's and St Thomas' Hospital in London had the pleasure of hosting Karin Hinterbuchner, a Nurse from Innsbruck Hospital in Austria, who shadowed the Advanced Clinical Practitioners and Clinical Nurse Specialists within their Cardiac Surgery department.

Ana's story
Advanced NAHP roles are vital in delivering high-quality, patient-centred care. During Karin's time in the UK, we were delighted to ignite her passion for these advanced NAHP roles and show how they enable a highly autonomous way of working. It is hoped that they will become integrated into the Austrian healthcare system for cardiothoracic patients soon.

I was incredibly proud to mentor Karin during her fellowship. I truly wish that NAHP's had more opportunities embedded within our training and development to visit other centres, both here and internationally. These experiences can help us improve our services, drive change, increase morale and fulfilment at work.

We hope Karin's perseverance will help to drive progress in developing these roles within Austria's healthcare services. Sharing experiences like these not only enriches our practice but also fosters a sense of unity and progress within the global NAHP community.

Research and audit update

Upcoming 2025 SCTS National Research Meeting

- Planned virtually on Friday 7th November 2025. Research abstract submissions for the NAHP oral abstract sessions opened on 1st July 2025.

Forthcoming research projects

- 'Barriers and facilitators in conducting research in cardiac surgery' – survey form will be sent to each centre once ethics has been approved. If you would like to get involved, please contact Nisha Bhudia: **n.bhudia@rbht.nhs.uk** or Daisy Ezakadan: **daisy.ezakadan@nhs.scot**

"Nursing and Allied Health Professionals are a rapidly growing group within our SCTS family, who play a vital role in the delivery of high-quality patient care."

Karin Hinterbuchner, Innsbruck Hospital, Austria and the cardiac surgical team at Guy's and St Thomas'

- The Associate PI Scheme in a number of cardiac surgery trials run by the Cardiac Surgery National Trials Initiatives, (including the AFFECT trial, FARSTERS trial, ROSSINI, PROPHESY, TRICS IV). This will provide opportunities for NAHPs and medical trainees to get involved and be part of the delivery of high-quality randomised controlled trials. If interested, please contact Rosalie Magboo: **rosalie.renamagboo@nhs.net**.

Education

Kathryn Hewitt continues to drive NAHP education with passion and enthusiasm. Look out for upcoming webinars advertised on the website. The advanced cardiothoracic two-day course for NAHP's is planned for September 2025 and will be in person, so look out for the advert and apply early if interested.

NAHP core focus areas for 2025

- Team structure, recruitment and succession planning
- Research and innovation
- Website development
- Education
- Increasing NAHP membership

If you are a nurse or allied health professional interested in becoming more involved in collaborating with us and educating others nationally, please contact **amanda.walthew@lhch.nhs.uk**

Please encourage your teams to join us. The current fee (NAHP) is a one off £10 admin fee and £30 per annum. ■

SAC Chair Report

Timothy Jones, Chair of the Cardiothoracic Specialty Advisory Committee, Consultant Paediatric Cardiac Surgeon, Birmingham Children's Hospital

All training pathways begin with the appropriate selection of the most able, capable and trainable candidates. With the development of 'run through' training entry at ST1 takes an individual to CCT and the ability to apply for a consultant position.

Through appropriate assessment and feedback, the curriculum based training programme ensures trainees progress appropriately whilst providing additional time or opportunities for those who require it. In cardiothoracic surgery, the number of trainees who either voluntarily withdraw from or are removed from a training programme, remains extremely low. However, we cannot use these metrics as the only indicators of a successful recruitment and appointment process.

We have recently completed this year's round of national appointments, as we saw our highest number of applicants. Since the COVID-19 pandemic, we have been rigorously lobbying for a return to face-to-face selection, however, this is unlikely to occur in the foreseeable future. We have therefore been developing the process of selection using an online platform. This year we included a communication station using professional actors and we developed our structured questions to better test higher order thinking. Steven Tsui, previous lead for national selection, has handed this over to Steve Woolley who with members of the National Selection Board continue to work very hard to improve and refine the processes whilst ensuring they are fair, reliable and meet national standards.

Sadly, we have evidence of recording and sharing of the interview questions potentially giving some applicants an unfair advantage. The changes we have introduced have significantly helped eliminate this effect. The regulations remain the same that anyone recording, disseminating and/or benefitting from shared questions, will have their national appointment withdrawn. The JCST has reiterated they are enforcing this regulation as well as reporting anyone using previously recorded questions to the benefit of a candidate, to the GMC on probity. We will continue to work to ensure the recruitment processes are fair and transparent.

> **"To better understand career pathways, from August 2025 all Phase 2 and 3 trainees will need to record on ISCP their chosen career path – thoracic or cardiac (including congenital cardiac). This will help us ensure regions can deliver the required speciality training."**

Whilst the recruitment processes need to select the best candidates, we also must ensure we appoint the appropriate number of people on an annual basis to our training programmes. Too few will leave a shortage in the workforce and whilst too many will drive up competition for consultant jobs, it is inappropriate to train too many people for too few jobs. Mark Jones, our Workforce Lead, has done an excellent job in completing the recent combined SCTS and SAC Workforce Survey, published earlier this year. This gives us a greater overview and understanding of workforce requirements and trends. The impact of lung cancer screening has necessitated an increase in the number of thoracic consultants which we responded to by appointing additional thoracic themed training posts at ST4. Working with NHS Employers, the SCTS and the Thoracic Forum, it is likely the increased need is now being met. Consequently, there will only be one more round of thoracic recruitment at ST4 in 2026 and no further ST4 recruitment thereafter. At the same time, there will be a progressive increase in the number of ST1 posts advertised over the coming years.

To better understand career pathways, from August 2025, all Phase 2 and 3 trainees will need to record on ISCP their chosen career path – thoracic or cardiac (including congenital cardiac). This will help us ensure regions can deliver the required speciality training for their trainees' needs and provide an estimate of sub-speciality numbers for the intercollegiate exam.

The quality assurance of training remains one of our highest priorities. In previous editions of *the bulletin*, we have outlined measures being taken to optimise training opportunities and particularly to increase trainees time in the operating room. Shahzad Raja, our QA Lead, compiles the annual quality reports for all regions and is working hard to use this cumulative data to produce a more in-depth analysis of quality in individual regions, highlighting areas for improvement. Overall, we are seeing less pink and reg flags across regions, but there is still more work to be done.

As with all data, the outcome is dependent upon the input and whilst we have seen an increase in trainee engagement with the GMC and JCST Training Quality Surveys, we need to see more trainees entering data. All trainees must complete the JCST Survey on completion of each placement and the GMC Survey on an annual basis. Trainers should complete the GMC Survey every year and the JCST every two years. We will continue to highlight when these surveys are due via the SCTS Weekly Updates.

In association with the quality reports and thanks to the work of Josh Lodhia and Simon Thomson, eLogbook is providing more in-depth, real-time data for trainees, trainers and Training Programme Directors on a number of training cases for both trainee and trainer, as well as trainee progression and benchmarking with peers. However, this requires all trainees and trainers to be registered with eLogboook, which is an easy on line process, and for all trainees to ensure they have validated their NTN placement on ISCP with their TPD. Without doing this, data cannot be used for eLogbook outputs or for the GMC and JCST Surveys.

In previous articles we have summarised the changes being made to update the 2021 curriculum by Elizabeth Belcher and Mahmoud Loubani. These changes are to ensure the curriculum remains current, reflecting contemporaneous practice as well as increasing the range of index and major cases. Any changes will be introduced in a staged approach not to disadvantage more senior surgeons in training. The proposals are currently under review by stakeholders and subsequently the GMC. We will ensure there are appropriate communications and publicity prior to the implementation of the changes which is anticipated towards the end of this year. In the meantime, the list of WBAs and notably PBAs has been refined and updated to better reflect curriculum requirements. PBAs that have been removed, have been archived so will not be deleted from trainees' records or numbers.

I have mentioned just a small number of the 14 elected and 12 invited members of the SAC. All their work is voluntary with the sole aim of improving training for the benefit of our patients. If you are interested and committed to developing and improving training and would like to become a member of the SAC, please contact either me or any SAC member. We are recruiting 2-3 new members per year.

Finally, I would like to thank Bassam Gadallah and Walid Mohamed, who have recently completed their terms as trainee representatives on the SAC, for all their work and an excellent job. We welcome Mohamed Sherif and Ali Ansaripour who takeover the roles.

If you require any further information or want to discuss any of the above, please do not hesitate to contact either me or our trainee representatives Mohamed and Ali.

tim.jones9@nhs.net ■

SCTS Education Secretaries Report

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

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

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

Prof Mahmoud Loubani, SCTS Tutor, Consultant Thoracic Surgeon, Castle Hill Hospital, Hull

Cardiothoracic surgery continues to offer a uniquely challenging yet rewarding career path, demanding sustained excellence, technical acuity, and unwavering commitment. As the educational landscape evolves in the face of fiscal constraints and institutional changes, the SCTS Education Committee continues to deliver comprehensive, curriculum-aligned opportunities for surgical trainees across all stages of training. The ethos of SCTS Education remains rooted in professional integrity, inclusivity, and a steadfast commitment to training the next generation of cardiothoracic surgeons to the highest standards.

Progress and Challenges in Educational Delivery

The last 12 months have tested the resilience of our educational frameworks. The closure of the Johnson & Johnson Institute in Hamburg has meant we have to look for alternative venues for our live operating courses. Concurrently, broader financial pressures – both within the NHS and across our supporting organisations – have necessitated difficult but pragmatic decisions.

Notably:

- Course Viability and Cost-Recovery: A nominal delegate fee has been introduced for some of our educational offerings. This step, though regrettable, was essential to sustain the high-quality experiences we deliver. Feedback indicates that the courses remain excellent value and are highly rated by trainees.

- Live Operating Commitment: We continue to work closely with Medizin im Grünen to deliver a robust and well-structured live operating course in Berlin. Parallel discussions with Madrid are progressing positively, with a view to reintroducing live operating for the ST5 cohort, reverting from the current cadaveric format.

Leadership Transition and Faculty Recognition

The Education Subcommittee would like to congratulate our Co-Chair, Elizabeth Belcher for her appointment as Chair of the Intercollegiate Examinations Board in Cardiothoracic Surgery. Sadly however, this means Elizabeth will be demitting her role as Education Secretary. We would like to thank Elizabeth not only for all her hard work over the past three years, but also for many years before that as Thoracic Tutor, Course Director and Faculty member. Specifically, Elizabeth's hard work and tenacity were instrumental in the establishment of the SCTS RCS Edinburgh-accredited post-CCT Fellowships and the now well-embedded ST5.2 Critical Conditions Course. The improvement of access to SCTS Education for Trust Appointed Doctors is also a testament to Elizabeth's work during her time as Education Secretary. We wish her ongoing success in her new role.

We also wish to acknowledge:

- The commitment of the Education Subcommittee, whose members continue to uphold high standards despite growing operational challenges.

- The dedication of our Course Directors and Faculty, without whom the delivery of meaningful and progressive training would not be possible.

- Mara Banuta who is outstanding in her role as SCTS Education Administrator, puts in an enormous amount of hard work behind the scenes to ensure the courses run smoothly.

Industry support

SCTS Education would like to thank our industrial partners for their generosity and support in these challenging financial times. J & J Medtech continue to support many of our courses either partially or in full and we are grateful to them for their ongoing support.

SCTS Brand Partnerships are also held with Meril, Atricure, Artivion, Edwards, Acumed and Pulmonx.

We are excited to announce a new partnership with Edwards moving forward, which will support the rollout of Minimal Impact Surgery (MIS) in the UK. More details of this will be announced in due course over the coming months.

We are also delighted to announce a new partnership with Meril; more details to follow soon.

Funding courses has become increasingly challenging due to rising costs and compliance constraints associated with non-technical courses. We have combined the ST2 courses into a single course, facilitated by the reduced requirement for didactic course teaching through the launch of the National Online Curriculum Webinar Series.

Transplantation

The SCTS Harefield Thoracic Organ Transplantation Course was held at the STaR Centre, Harefield Hospital and we are grateful to Espeed Khoshbin for his leadership of the Transplant Education programme.

NAHP Education

The NAHP portfolio continues under the leadership of Kathryn Hewitt, whose webinars have received fantastic feedback. A face-to-face cardiac and thoracic course for NAHP is being planned this autumn at the Getinge Facility in Derby.

SCTS Student Education

We are grateful to Jason Ali and Shilajit Ghosh, our SCTS Student Education leads, as well as all the medical students who lead and run the SCTS Student programme. A new committee has recently been appointed, and a further engagement day will be announced in the Autumn. The mentorship programme has allocated 38 students with mentors this year. An elective bursary competition awarded two prizes, having secured funding from Concentric Health and the Medical Defence Union. A new monthly journal club is running, focusing on appraising important research studies across the specialty. The committee is in the process of organising 'Med-Prep', a week of online seminars aimed at helping 6th form students prepare for medical school applications, which will run in September.

Fellowship Awards

The Heart Research UK Travelling Fellowships for 2025, totaling £40,000, have been advertised and the winners will be announced shortly. The Aortic Centre Trust Michael Warburg Fellowship for 2025 has now been advertised. We are grateful to both charities for their ongoing support of SCTS members. We encourage potential applicants to plan Fellowships as soon as possible. Applications for all Fellowships must be detailed regarding the proposed project plan and include support from their current institution and the fellowship centre. Details of projected costs and the subsequent benefit to the NHS are also vital to a successful application.

SCTS and RCS Edinburgh Post-CCT Fellowships in Cardiothoracic Surgery

SCTS and RCS Edinburgh Post-CCT Fellowships have been developed to provide high-quality, high-prestige and quality-assured training in complex cardiothoracic surgery. This is a service requirement, and independent practice at this level is beyond that required for CCT. Andrew Brazier has been appointed to the Liverpool Complex Aortic Surgery Post-CCT Fellowship, with a second award being announced shortly. Jennifer Williams has completed the Barts Robotic Thoracic Surgery Post-CCT Fellowship. Fellowships are also available at Barts Aortic Centre and the Bristol Heart Institute. Applicants should have been admitted to the Cardiothoracic Surgery Specialist Register of the GMC or the Medical Council in Ireland or comply with the certification requirements. Posts are also open to consultants within two years of appointment.

NTN Portfolio

The SCTS Revision and Viva Course was held in March using a hybrid format for the first time. Delegates had two days of teaching via the National online platform, followed by two days of face-to-face viva teaching at Ashorne Hill. The ST5.2 Cardiothoracic Intensive Care and Critical Conditions course also ran in April at Ashorne Hill, and in May, the ST3.1 Operative Surgery course recently ran again at Medizin in Grünen near Berlin. In June, the ST4.2 Core Thoracic Surgery Course was held at the Johnson & Johnson Institute, Pinewood Campus and the ST7.1 Pre-Consultant Course was held at Keele Anatomy and Surgical Training Centre. We are grateful to all course directors and faculty who worked to deliver these courses, led by Mahmoud Loubani and Mike Shackcloth. There is an expectation that all SCTS member national trainees will attend courses appropriate to their year of training, which are aligned with the current curriculum.

TAD Education

In line with the SCTS strategy of increasing equality of opportunity, we continue to improve access to education for our Trust Appointed Doctors (TADs). This year, the TAD Wetlab was funded by J&J Medtech and ran at their Pinewood Facility. The TAD Curriculum Review Course will also be run at Pinewood and is again funded through the generous support of J&J Medtech. The Portfolio Route (previously CESR) Course will run again in November at Ashorne Hill as a one-day review for senior TADs who plan to enter the specialist register via this route. All TADs sitting the JCIE May 2025 diet who are SCTS members, were able to access a place on the Revision and Viva Course. We have developed this strategy to minimise differential outcomes. In addition, we will continue offering TAD trainees places in as many of our NTN courses as possible. We thank Anas Boulemden and Mohammad Hawari, who lead the TAD Portfolio.

As ever, our work will be guided by feedback from trainees and trainers alike. The SCTS education committee remains committed to fostering an environment where surgical education is progressive, inclusive and responsive to the changing needs of both service and workforce. ■

Course	Location	Date
ST2 Essentials in Cardiothoracic Surgery	Nottingham Surgical Skills Centre	22nd - 23rd September 2025
TAD Curriculum Review Course	Pinewood	24th - 25th September 2025
ST5.1 Phase 2: Cardiothoracic Surgery Sub-specialty Course	Madrid	2nd - 3rd October 2025
Portfolio Route Course	Ashorne Hill	7th November 2025
ST4.1 Core Cardiac Surgery Course	Ashorne Hill	18th - 19th November 2025
ST7.2 Leadership & Professionalism Course	Ashorne Hill	27th - 28th November 2025
ST1 Introduction to Cardiothoracic Surgery Course	Ashorne Hill	5th December 2025
ST3.2 Phase 1: Non-Operative Technical Skills for Surgeons (NOTSS)	Bristol Simulation Centre	TBC

Communications Committee Report

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

The communications have evolved and progressed since the last bulletin; it was only possible with our committee members' enthusiasm who give their valuable time. I realised I was bidding an early final message as my term as communication secretary was for a three-to-five-year period and I accepted the extension to complete the term at the request of the executive committee.

We thank Emma, Tilly, Mara and Taet for their hard work in delivering our various projects.

Bulletin

the bulletin, under Dio as Editor, steps into the third issue and eco-friendly and sustainable model. Dio has firmly put his mark on the role and has taken it to better heights.

From the President's Desk

Our new President Aman Coonar writes to the membership every week and after various combinations, we have agreed to have it on the website, socials and at the top of our SCTS weekly E-Newsletter. We value any feedback on the process and content to improve things.

From the Chest

We are continuing with From the Chest in keeping to four issues and we welcome articles. You should be in receipt of the second issue of 2025 by the time *the bulletin* reaches you.

Website and Social Media strategy

As you will have heard from the President in his FTPD, we are looking at a new digital strategy with more involvement from public and patients.

We will have a Friends of SCTS and a Donate to SCTS section as well to support SCTS activities.

Executive report & BORS report

The Executive report of the activities of the SCTS committees will have reached you by now. We thank all the committee chairs and members for their hard work.

We will reach out to the BORS leads requesting data for the BORS report.

Social Media

The SCTS social media policy has been written and approved and circulated to members. We have keen members within the communications committee, who will be the SCTS Ambassadors in social media increasing our web presence. We request members to tag SCTS in your social media posts.

Communication

"Great communication begins with connection."
– Oprah Winfrey, television producer and host, author, philanthropist

We at SCTS are striving hard to reach the membership, other members of the fraternity, patients and public; Please connect with us to make communication effective and more beneficial. ■

New appointments January 2025 to August 2025 ...

Name	Hospital	Specialty/Role	Starting Date
Alan Dawson	Glenfield Hospital, Leicester	Locum Consultant Thoracic Surgeon	February 2025
Yama Haqzad	Leeds General Infirmary	Substantive Consultant Cardiac Surgeon	February 2025
Stylianos Gaitanakis	Bristol Royal Infirmary	Substantive Consultant Thoracic Surgeon	March 2025
Robert Nicolae	Morriston Hospital, Swansea	Consultant Thoracic Surgeon	March 2025
Azhar Hussain	St George's University Hospitals NHS Foundation Trust	Substantive Consultant Cardiac Surgeon	April 2025
Marco Nardini	St James's University Hospital, Leeds	Substantive Consultant Thoracic Surgeon	May 2025
Adnan Raza	Castle Hill Hospital, Hull	Consultant Thoracic Surgeon	May 2025
Saif Mohamed	Royal Sussex County Hospital	Consultant Cardiac Surgeon	June 2025

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Please see Full Prescribing Information.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard
Adverse events should also be reported to medinfo@pharmapal.co.uk

References:
1. Custodiol Solution for cardioplegia / organ preservation. Summary of Product Characteristics, 2024;
2. Hummel B. et al. Innovations 2016;11: 420-424

Adult Cardiac Sub-Committee Report

Manoj Kuduvalli, SCTS Adult Cardiac Surgery Co-Chair, Consultant Cardiac Surgeon, Liverpool Heart and Chest Hospital

Harikrishna Doshi, SCTS Adult Cardiac Surgery subcommittee Deputy Chair, Consultant Cardiac and Transplant Surgeon, Golden Jubilee National Hospital, Glasgow

Management of chronic aortic dissection

SCTS has been asked to engage with NHSE along with the Vascular and Cardiology societies to develop a pathway for elective management of patients with chronic dissection, with a broader scope to include identifying at-risk individuals (family screening where appropriate) and managing patients with incidental finding of aortic aneurysms, for example, through a Targeted Lung Health Check CT scan. This work is in the initial stages, and different workstreams are being formed to feed into a comprehensive guidance document.

Engagement with NICE

SCTS, via the ACSSC has engaged with NICE as stakeholders on various guidance and technology assessments.

- **Completed: Interventional procedure:** ACSSC is currently involved with NICE for Interventional Procedures: New Guidance in development: IP1071/2: Venoarterial Extracorporeal membrane oxygenation (VA ECMO) for acute heart failure in adults. Proposed recommendations have been published and are currently under final discussions. They are likely to be published soon.
- **Completed:** Decision making aid for stable angina
- **Completed:** TAVI for Aortic Incompetence
- **Ongoing: Interventional Procedure:** ACSSC is currently involved with NICE for providing Professional Expert Advice for Insertion of a catheter-based intravascular microaxial flow pump for cardiogenic shock (IP2042)

SCTS Position statements, discussions on proposed guidelines

ACSSC has been tasked with deliberating and creating position statement for SCTS by the Execs. Similarly, when guidelines are submitted for support or validation by the SCTS, ACSSC is tasked to review them and submit further comments. During last year, projects undertaken includes;

SCTS position statement regarding management of patients with multi vessels Coronary artery disease in response to the 2024 European Society of Cardiology (ESC) guideline for the management of patients with chronic coronary syndromes. It was published by SCTS in September 2024.

GIRFT Pathway for patients with AS: ACSSC was invited to discuss and comment on the Cardiology GIRFT AS pathway. Following discussions, recommendations have been submitted.

National guidelines for glycaemic control for patients undergoing Cardiac Surgery: ACSSC was asked for comments on proposed National guidelines summary review for glycaemic control for patients undergoing cardiac surgery. It has been discussed and submitted.

SCTS endorsement for BHVS statement: British Heart Valve society (BHVS) Council has agreed to publish a statement on the need for rapid treatment of symptomatic severe heart valve disease with an intention to help patients and to provide an incentive for the relevant bodies to fund and develop services accordingly. BHVS approached SCTS to endorse the document. ACSSC was tasked to discuss and comment on the statement. Recommendations have been submitted to SCTS exec committee following these discussions.

SCTS position statement regarding provision of Post Cardiotomy ECMO support at Non transplant Cardiac Surgical units in United Kingdom. ACSSC was tasked by the SCTS Execs to discuss and create the consensus statement. The draft statement was submitted by ACSSC to the Execs. It was published by SCTS in June 2025.

National Guidelines for Adult Mitral valve disease: This has been discussed at the level of ACSSC and approved by the Execs for final publication soon.

Ring-fencing resources (ward and CCA beds) for elective cardiac surgery

SCTS, with input from the ACSSC, published a letter of support for ring-fencing resources for elective cardiac surgery, particularly focusing on critical care beds. This was published working alongside colleagues from ACTACC.

Other areas of engagement

- Working with SCTS Research to recruit to large multi-centre research trials to help further demonstrate the efficacy of surgical intervention.
- The ACSSC continues to engage with NHS England to promote the excellent surgical outcomes of cardiac surgery achieved in the United Kingdom & Ireland. The SCTS is also lobbying the government through the Royal College of Surgeons to increase funding and resources to support initiatives to tackle the waiting lists and backlog.
- Review of cardiac surgery service specification for Wales.
- Ongoing development of guidance documents for SAVR vs TAVI. ■

Thoracic Surgery Sub-Committee Report

Karen Redmond, SCTS Thoracic Surgery Sub-Committee Co-Chair,
Consultant Thoracic & Lung Transplant Surgeon, Mater Misericordiae University Hospital, Dublin

Rory Beattie, SCTS Thoracic Surgery Deputy Chair,
Consultant Thoracic Surgeon, Royal Victoria Hospital, Belfast

It's been another busy six months for the Thoracic Sub-Committee – lots of progress, with more coming to fruition over the next few months. Doug West has been appointed the new SCTS Honorary Secretary earlier this year and will take over from Rana Sayeed as our Executive Co-Chair. We'd like to thank Rana for all his support and collaboration through the years. Gary Fitzmaurice will take over from David Healy as Republic of Ireland Rep, with Maninder Kalkat and Edward Caruana joining as Airway and Diaphragm Reps respectively.

Babu Naidu has led the **Thoracic Surgery Priority Setting Partnership**, securing funding to work with the James Lind Alliance in identifying the top 10 research priorities in Thoracic Surgery for years to come. Surveys for patients and all members of the healthcare team have been circulated via the Thoracic Forum and local unit champions, with the synthesis of responses beginning over the summer.

To date, the level of national data collected is minimal, mostly focusing on case numbers. Kandadai Rammohan and Nathan Burnside have re-explored the possibility of an **SCTS thoracic surgical database** and secured funding to develop this with Dendrite. The aim is to collect data across the full spectrum of thoracic surgical pathology; gathering information on patient characteristics and procedural data, along with outcome data including mortality and patient reported outcomes. Units currently using both Dendrite and non-Dendrite databases will be encouraged to contribute and will be able to submit their own research proposals on this national-level dataset. After input from the Thoracic Forum, we're finalising the desirable data fields and will link in with unit audit leads to map existing databases to the SCTS fields.

The **Pectus Working Group** continues to move from strength to strength. The RESTORE trial has now finished recruitment, with results due late 2026. The **Trauma Working Group**, in conjunction with the British Orthopaedic Association (BOA), has approached Getting It Right First Time (GIRFT) to create a multispeciality best practice guidance on patients with blunt chest trauma. The ORIF trial is due to report later this year, and we hope to be able to incorporate this into the pathways. Doug West has led the roll out of the **NCIP Portal for Thoracic Surgeons** in England, while also leading the GIRFT pathway on **Surgery for Pleural Sepsis**.

With new appointments for Airway and Diaphragm, we are looking to create working groups and develop best practice pathways for these conditions. The Thoracic PSP will highlight the key research questions in thoracic surgery, and we envisage the new SCTS Thoracic database being able to help answer at least some of these. As always, if you're looking to get involved with anything we're doing, please drop us an email. ■

Congenital Sub-Committee Report

Andrew Parry, SCTS Congenital Cardiac Surgery Co-Chair,
Consultant Congenital Cardiac Surgeon, Bristol Royal Hospital for Children

There are 2 major themes that the congenital subcommittee have been concentrating on over the last year;

- Maximising throughput particularly during the winter season
- Developing a strategy to address the loss of senior surgeons

The congenital cardiac programmes in the country are particularly at risk during winter months when respiratory infections increase demands on PICU, reducing the bed base from which we can work as most of the services function out of combined PICUs. In addition, like other sub-specialities, there has been a remarkable difficulty in regaining momentum following the COVID shut down.

The various representatives have shared local individual efforts to address these issues and from the discussions, these initiatives (such as immediate sending for cases at the beginning of the day prior to 'bed meetings', development of HDUs to allow LTV (Long Term Ventilation) patients to avoid PICU

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admission etc.) have been fine-tuned then also adopted by other centres. We await feedback on the efficacy of the various initiatives. We acknowledge that there is no 'quick fix' but marginal gains throughout the pathway have enabled individual centres to increase throughput and all representatives are keen to take advantage of these experiences. Repeated case cancellations is identified as one of the leading frustrations in the speciality that is causing consultants to review their options.

It is well known that UK trained doctors, not infrequently, emigrate even in their later years leaving our workforce challenged by a significant loss of experience. The reasons for this have been studied by both the BCCA and, more widely throughout medicine, by the GMC and are remarkably similar between the two studies. Suffice it to say that approximately 40% of the consultant congenital cardiac surgical population has been lost over the last 8 years and a further 15% are projected to leave over the next 5 years.

Along with the BCCA, we have been exploring what can be done to decrease the number of consultants lost to emigration and it has been recognised that the key issue is morale. After consulting widely within our community, the main reasons for this loss of morale have been identified key amongst which are frustrations with the provision of services for congenital heart surgery, specifically the lack of PICU facility and the frequent cancellation of cases.

The subcommittee is currently in the process of developing a document "Congenital Cardiac Surgery; what a good unit looks like" which will be circulated to all the consultant congenital surgeons for agreement before being more widely circulated. It is intended that once agreed, this document will be shared with the replacement for NHSE in order to start a dialogue so that we can ensure the speciality remains appealing and challenging throughout the whole of a consultant career to minimise the draw of an overseas experience.

There is a feeling amongst the subcommittee representatives that appointed congenital consultants are exposed in their professional work place as the exit exam does not test any level of knowledge of congenital heart surgery in Section 2 clinical exam. With the latest evolution of the JCIE CTh examination (in which there is an oral exam which tests the specific cardiac or thoracic declared candidates in their chosen sub-speciality) and the newly revised syllabus, there is an opportunity that those candidates who intend to pursue a career in congenital Cardiac Surgery, could be examined in this sub-speciality within the structure of the new exam. Discussions have been opened with the examinations board to explore the feasibility of this development.

Finally, the education element of the congenital subcommittee has been active and continues to run many hands-on courses for aspiring congenital cardiac surgeons which have been keenly appreciated. Current challenges in continuing delivery of this enterprise are mainly due to sponsorship and funding; these challenges are being actively explored. ■

Intercollegiate Specialty Board in Cardiothoracic Surgery

Sri Rathinam, Chair, Intercollegiate Specialty Board for Cardiothoracic Surgery JCIE, Consultant Thoracic Surgeon, Glenfield Hospital, Leicester

The exam board membership is complete with representatives from all stake holders.

Mr Sridhar Rathinam	Chair (22-25)
Miss Elizabeth Belcher	Chair Elect (25-28)
Miss Juliet King	Leader, Panel of Question Writers [S2]
Mr Neil Cartwright	Leader, Panel of Question Writers [S1]
Mr Rana Sayeed	JSCFE Lead
Mr Steven Rooney	RCSEd
Professor Farah Bhatti	RCSEng
Mr Vincent Young	RCSI
Mr Manoj Kuduvalli	RCPSGlas
Mr Tim Jones	SAC Chair
Mr Andrew Parry	SCTS
Mr Mark Jones	SCTS
Ms Rebecca Weedle	Trainee Representative
Mrs Elaine McDaid	Specialty Manager

I complete my term as Board Chair and congratulate and welcome Elizabeth Belcher as the new Board Chair. Elizabeth has done a stellar job as the Section 1 lead.

We thank Claire Digence-Fisher for her excellent contribution as specialty manger of cardiothoracic section who now has moved on. We welcome Mrs Elaine McDaid who conducted the first exam with our team in Blackpool to great efficiency and diligence.

We welcome Neil Cartwright as the new Section 1 lead and Mr Andrew Parry and Mr Mark Jones as SCTS representatives.

Panel of Examiners

The panel of examiners is in a better shape – the big recruitment drive has increased the

examiner pool with more thoracic examiners, female examiners, and examiners from all four nations and the Republic of Ireland. Special efforts have been made to recruit more female examiners to reflect our trainees. At the discretion of the board based on performance, the JCIE now offers an option for examiners to be in the panel after completion of two terms as examiners, which has allowed a few of our colleagues to extend their roles and service to the JCIE.

Assessor

We welcome senior examiners who have completed two terms and wish to support the exam process by becoming accessors.

Time and Leave for Exam Related Duties

It is timely the CMOs of the four nations have posted a publication update with regards to employers releasing surgeons for wider NHS roles including exam related activities.

Blackpool Examinations

We have recently conducted the 6th diet of the new format examinations with patient volunteers and sub-specialty vivas in Blackpool. This was big exam with eight pairs of examiners for each specialty to reduce the waiting lists.

The host examiners were Prof Mohamed Nidal Bittar and Mr Manoj Purohit who delivered the local patient volunteers, support team and instruments; It was challenging with a need for increased number of patient volunteers due to parallel circuits for the candidates requiring extra time. A big thank you to Nidal and Manoj who supported the exams and all the juniors who helped with the exam.

Waiting Lists for Section 2

With the new format examinations and chosen specialty interest, we now have waiting lists for Section 2 examinations particularly for cardiac themed trainees. JCIE will offer a place for Section 2 on a first come, first served basis, according to the time of submission of application for Section 1. Applications from NTNs and TADs will be maintained in a common list. We urge all candidates to take their exams at the earliest opportunity so that the exams don't impact of consultant posts and fellowship plans.

We have reduced the list by expanding examiner pairs in Blackpool and are working with the secretariat towards solutions to increase the number of candidates in each diet.

Juliet King, Section 2 Lead; Sri Rathinam, JCIE Chair; Elizabeth Belcher, Section 1 Lead

Standard Setting and Question Writing

A big thank you to Elizabeth Belcher and Juliet King who led on the Question writing groups and Mark Jones who supported Juliet with the cardiac questions.

We are cited as a role model to other specialties as we have a robust standard setting process including having marking standards agreed prior to the exam.

Joint Surgical Colleges Fellowship Examination

The JCIE is exploring options regarding the future of the JSCFE examinations with various options explored to support the candidates. Candidates who have passed the section 1 of JSCFE can now appear for the JCIE exam if they have worked in the UK or Ireland for one year. It has been decided we will have two diets of exams in the UK for those successful in the Section 1 in 2025 and 2026 after which the exam will be stopped.

Future Examinations

The next examination will be held in London (Ealing) hosted by Mr Sunil Bhudia and colleagues on 21st-23rd October 2025.

The following diets of the Section two will be held in Stoke-on-Trent in May 2026.

New Examiners

We are grateful to all the new examiners who have made important contributions to the examinations.

We welcome experienced surgeons and trainers who have completed 5 years of substantive posts and are in good standing to consider joining the court of examiners. There will be a lead time of 12-24 months before you will examine, as your application will be assessed by the board. You will then be invited to the examiner training following which you will observe an exam before formally examining in a diet.

It is time to thank all my examiners, the board members, the JCIE board, the secretariat staff and hand over the reins to Elizabeth Belcher and wish her all the best. ■

A fond farewell from the 2023–2025 Student Education Committee

Heen Shamaz, SCTS Student Education Lead
Emma McEwen, SCTS Student Events Lead
Martin Ho, SCTS Student Education Medical Student Liaison Lead
Alana Atkinson, SCTS Student Eduction Widening Participation Lead
Jason Ali, SCTS Student Education Cardiac Lead.
Locum Consultant Cardiothoracic Surgeon, Royal Papworth Hospital, Cambridge
Shilajit Ghosh, SCTS Student Education Thoracic Lead.
Consultant Thoracic Surgeon, Royal Stoke University Hospital

The 2023-2025 student education committee term may be coming to an end, but this hasn't stopped us from continuing to educate and inspire our student community! From the Annual Medical Student Day in Edinburgh, to our online Journal Club, we hope you enjoy reading about our highlights from the last few months and take a sneak peak into our plans for the future!

Medical Student Session at Annual Meeting

At the SCTS 2025 Annual Meeting in Edinburgh, the SCTS Student Education Committee (SEC) hosted the medical student session. We were honored to host several guest speakers – Ralitsa Baranowski, Vivian Bader, Vipin Zamvar and Daniel Sitaranjan, who educated students on the sub-specialties within cardiothoracics. They shared a deeper understanding of the specialty, including lifestyle considerations, and personalised advice on career pathways and applications.

Additionally, medical students received practical, hands-on sessions as part of the NAHP Wetlab. These included coronary anastomosis, chest drain insertion, thoracic echo and more!

The day concluded with a very engaging panel discussion with Aman Coonar, Jason Ali, Elizabeth Belcher, Debbie Harrington and Shilajit Ghosh, where students in the audience asked questions and debated topical issues within the specialty. This proved to be a very thought-provoking and interesting discussion, which renewed confidence in the future of cardiothoracic surgery.

Journal Club

This academic year, we launched a new journal club initiative aimed at introducing students interested in cardiothoracic surgery to current research. Across six interactive sessions, we explored a diverse range of topics, from early lung cancer management to comparing traditional open-heart surgery with newer minimally invasive approaches.

Altogether, 119 students and resident doctors from across the UK and Ireland participated in the journal club, with many participants attending multiple sessions. Feedback was overwhelmingly positive, with students reporting greater confidence in reading and appraising scientific literature. This initiative has proven to be a valuable platform for nurturing academic curiosity and building essential research skills in future cardiothoracic surgeons.

Regional Leads

Following positive feedback from the inaugural year of our Regional Leads initiative, we are excited to announce the successful conclusion of its second year! Currently, over two-thirds of medical schools across Ireland and the UK are represented by an SCTS Regional Lead, marking a significant increase from the previous year.

Regional Leads support the SCTS SEC by promoting events within their medical school, ensuring that all medical students, regardless of their location, can access information and events related to cardiothoracic surgery.

If you are a keen medical student in Ireland or the UK, we will soon be accepting applications to become a Regional Lead for the 2025/2026 academic year. You will work with key members of the SCTS SEC, receiving first-hand information on upcoming SCTS events. Moreover, you'll have the opportunity to help grow the student community interested in cardiothoracic surgery.

Teaching Series

Following a successful six-webinar series delivering information about the application process and training within cardiothoracic surgery, it was decided to run the series for a second year. The first cycle reached over 300 attendees from over 40 different countries and received overwhelmingly positive feedback, highlighting the need for greater awareness.

This year the webinars covered how to make a competitive application, the journey through cardiothoracic surgery, a guide to MRCS and surgical portfolio, academic surgery, alternative pathways, and life after a training number. This diverse range of topics gave attendees a greater insight into training and how to apply to this highly competitive specialty.

The aim was to widen participation within cardiothoracic surgery, whilst

educating the next generation of surgeons. This series remained free to attend, was easily accessible on MedAll and provided an honest overview of a diverse range of speakers' experiences. We hope that this series has broken down some of the potential barriers, helping to encourage all students and resident doctors to feel empowered to pursue a career in cardiothoracic surgery.

Elective Bursary Competition

This spring marked our inaugural elective bursary competition, kindly sponsored by The Medical Defense Union and Concentric Health. The initiative aims to help students develop their understanding of cardiothoracic surgery while tackling some of the financial barriers which can limit opportunities for students.

Applicants were asked to share their motivations for pursuing an elective in cardiothoracic surgery, and their vision for what "Generation Z" can contribute to the future of the specialty. We were very impressed by the high standard of applications, making the selection process very challenging. After careful consideration, we are thrilled to announce the winners: in 1st place, Sarah Guo and in 2nd place, Esther Sleigh. Congratulations to both! We hope you and everyone who applied have a wonderful time on your elective!

MedPrep

MedPrep is our renewed initiative aimed at inspiring and preparing 6th form students for a career in medicine. Following the success from the widening participation work experience placements last year, we have expanded to more centers across the nation this year- Edinburgh, Cambridge, Glasgow, Hull, Brighton, Middlesbrough and the West Midlands. Our aim is to roll out this initiative to every center in the UK/Ireland, so if you aren't already involved, please do get in touch!

Additionally, as part of MedPrep we are planning an online lecture series, open to all high school students and medical students. Keep a lookout on our socials for more details this summer!

Website Updates

This year, we've made several exciting updates to the Medical Students section of the SCTS website to improve accessibility and support for students.

A new shared calendar allows students to easily stay up to date with upcoming events and opportunities. We also launched an elective repository, featuring current information on electives in cardiothoracic surgery across the UK and Ireland, including available centers, cost and additional requirements, as well as contact details for students to get in touch. Additionally, we have a summary of foundation year rotations that include cardiothoracic surgery posts, helping students plan their early career paths more effectively.

These changes make it easier for students to find key information and make the most of the opportunities available as they begin their career into cardiothoracic surgery, so do drop by our section of the website!

One final word...

As our term comes to a close, we want to say thank you to every student and guest who supported our initiatives in these past 2 years. We have loved working together to inspire the next generation of surgeons, and it has been an honor to represent the student voice. It is certainly a bittersweet moment for us; however we have no doubt that the future of this committee and specialty is bright.

Signing off,
2023-2025 Student Education Committee ■

Strengthening the Trainee Voice: Curriculum, Careers and the Road Ahead

Ali Ansaripour & Mohamed Sherif,
National Cardiothoracic Surgery Trainee Representatives
On behalf of the NTCCTS

The National Trainee Committee for Cardiothoracic Surgery (NTCCTS) has entered a new phase in 2025, with a renewed focus on strengthening communication, representation, and collaboration across all UK training regions.

The committee includes representation from every deanery and has been structured to meet quarterly, aligned with key SAC and SCTS Executive Committee meetings. These formal touchpoints are supplemented by an active communication network that ensures every trainee – across all grades – has a direct voice and accessible route to feed back into national discussions.

This article marks the beginning of what we hope will continue to be a period of meaningful progress for UK cardiothoracic surgery trainees. While positive developments are underway, the NTCCTS sees this as a stepping stone towards much larger goals. These will only be achieved through close collaboration between trainees, trainers and the organisations that oversee our training and workforce planning.

Curriculum Changes and the Importance of Realism

One of the most important areas of recent activity has been the ongoing work around the cardiothoracic surgery curriculum revision. The NTCCTS has worked collectively with the SAC and JCST to ensure that the voice of trainees is reflected in the proposals submitted to the GMC. Our aim throughout has been to support a curriculum that prepares future consultants for the changing demands of the NHS and our specialty, while remaining realistic and achievable across all UK training centres.

This has been a truly collaborative process and we are grateful to all trainees who contributed through national channels.

> "Our aim throughout has been to support a curriculum that prepares future consultants for the changing demands of the NHS and our specialty, while remaining realistic and achievable across all UK training centres."

Looking ahead, it will be essential to monitor how these changes are implemented and ensure they are accompanied by the right opportunities and support across all sub-specialties and regions.

Exam Access: A Logistical and Financial Priority

FRCS examination access remains one of the concerns raised by senior trainees. In a recent national survey (40% response rate), over 50% of respondents reported being placed on waiting lists for the exam. Many highlighted delays to planned Out of Programme opportunities, fellowships, and even consultant appointments as a result.

Extending training solely due to exam access is not only frustrating for trainees, but costly for NHS Education providers and deaneries. This issue was discussed in detail at the June 2025 SAC meeting, and the NTCCTS will continue to work closely with the JCIE to ensure exam access improves and that no NTN trainee is forced to extend training due to circumstances beyond their control.

Phase 1 Reform: Laying the Right Foundations

Reforming Phase 1 training (ST1–3) is one of the most exciting and necessary projects currently underway. Our recent survey – completed by the majority of trainees at this level (70% response rate) – highlighted several key concerns. These include not only time spent in non-specialty aligned placements, but also variation in training quality during cardiothoracic placements themselves. The NTCCTS is working closely with the SAC to promote a best practice model for Phase 1 posts. This includes differential rotas with protected theatre time, clinics and MDT access to ensure early exposure aligns with curriculum goals. These early years are especially crucial given the condensed seven-year training structure now in place.

Workforce Planning: A Sensitive but Urgent Issue

According to the 2025 workforce report, nearly 60 new consultant posts are expected to be advertised in the coming years, alongside around 80 anticipated retirements across the specialty, including in congenital

and transplant surgery. This represents a significant shift in the consultant workforce and highlights the importance of preparing trainees to be competitive for these roles.

While we recognise the important contributions made by doctors from varied backgrounds – including Trust-Appointed Doctors, and international colleagues – it is essential that our training programmes prepare NTN trainees for consultant roles with the right experience, mentorship and support. Our curriculum must reflect real consultant practice, and trainees must be placed in units where there is a proactive approach to supporting senior trainees into substantive roles. We hope to see most of these new posts filled by NTNs at or near CCT, and will continue to work closely with the SAC and workforce planners to monitor this closely and advocate for our cohort.

Moving Forward

The NTCCTS exists to ensure that all competitively appointed National Trainees are represented, supported and heard. There is much more to be done, and we do not underestimate the challenges ahead. This year marks the beginning of a renewed, national conversation – led by trainees, supported by trainers, and focused on delivering the best possible outcomes for our future consultants and our patients. ■

Patient safety and quality improvement working group

Andrew Parry, SCTS Congenital Cardiac Surgery Co-Chair, Consultant Congenital Cardiac Surgeon, Bristol Royal Hospital for Children

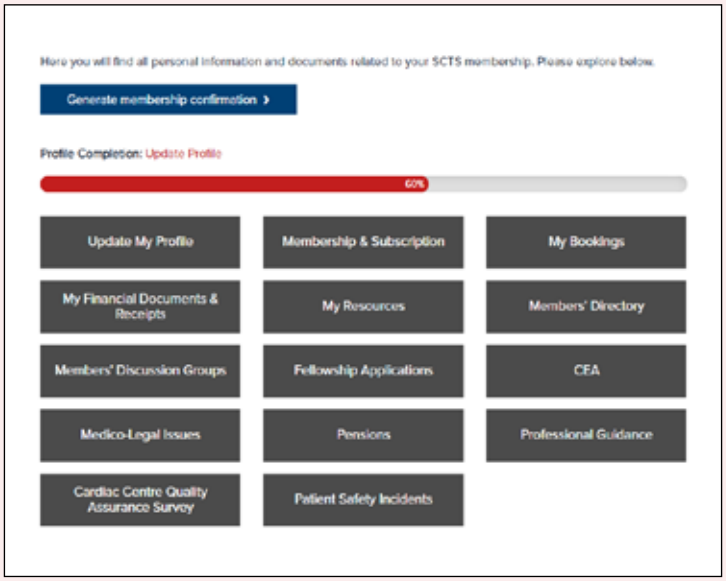
We all work within the NHS. The NHS charter states that patients '…have the right to expect NHS bodies to monitor, and make efforts to improve continuously, the quality of healthcare they commission or provide. This includes improvements to the safety, effectiveness and experience of services.'

Over the last few years the SCTS has been considering how we can best achieve this and concluded that the development of a repository of events that is accessible to all members would enable the dissemination of learning. This has taken a considerable length of time but is now active, and we therefore encourage colleagues to review the opportunity and contribute to our 'Library of Learning'.

Amongst the advantages of individual incident reporting, issues with rare cases (such as Mycobacterium chimaera) or equipment that might not trigger an alert in any individual unit may be identified by pooling our resources.

The purpose of incident reporting is to improve the safety of patients by ensuring that relevant safety information relating to cardiac surgery is reported, collected, stored, protected, exchanged, disseminated and analysed. It is not to attribute blame or liability.

All incident reports will be treated confidentially and there will be no unit identifiable data included on the library entry. Information can only be used for the purpose of maintaining or improving the safety of patients, and the release of incident information to the general public or the media will not be permitted.



The sharing of data about specific events is sensitive to Trusts and individuals, and approval may need to be obtained. Formal approval has been obtained from one Trust with a signed DPIA form documenting confidence in the level of data protection associated with the venture on the SCTS website. A copy of this form can be obtained if desired from Andrew Parry.

Initially the library will simply be a repository for the dissemination of learning though future developments may allow discussion and analysis of events or clusters.

It is envisaged that themes/ keywords of events submitted will be detailed in *the bulletin* and members can then access the event through the website. There may be an annual report produced for our fraternity highlighting the major topics, any themes that have been identified over the year, and significant learning that has come from these events.

Events can be submitted on the SCTS webpage (see left). Any further information can be obtained from: **andrew.parry@UHBW.nhs.uk** ■

Shaping a supportive future for women in cardiothoracic surgery

Reflections from the MWF panel: "Women doctors' careers – What are we doing? What needs to be done?"

WiCTS Report from the Medical Women's Federation Conference – May 2025
Ralitsa Baranowski, Co-Chair, Women in Cardiothoracic Surgery (WiCTS)

On 16th May 2025, the Medical Women's Federation hosted a landmark panel discussion titled "Women doctors' careers – What are we doing? What needs to be done?" bringing together voices from over 20 specialties, including cardiothoracic surgery. It was a striking reminder of how far we have come, but also how much work remains to ensure women doctors can truly flourish across all areas of medicine, including in cardiothoracic surgery.

Today, over 50% of doctors licensed to practise in the UK are women, with 57% of postgraduate trainees being female. Yet, despite these numbers, many of the systems, structures, and cultural expectations in which we train and work, still reflect assumptions from another era.

As a specialty, cardiothoracic surgery stands at a critical juncture. We pride ourselves on excellence and innovation, but we must also be leaders in shaping an environment where all talented surgeons can succeed, regardless of gender, caregiving responsibilities, or personal circumstances.

The recent Medical Women's Federation conference panel, joined by WiCTS, called for urgent but positive change: more flexible training, better support for parenthood, equitable opportunities in leadership and tackling everyday bias.

The importance of addressing barriers – but with optimism

During the MWF panel, we spoke candidly about the persistent barriers women face: The 91% of women doctors who report experiencing sexism, whether through microaggressions, biased assumptions about competence, or outright exclusion.

The rigid, rotational training structures that often clash with the realities of pregnancy, breastfeeding, or caring for family members, forcing many to make unfair choices between career progression and family life.

The continued underrepresentation of women in clinical leadership, meaning crucial decisions are still made without the full diversity of perspectives our workforce offers.

Yet amidst these challenges was a powerful sense of optimism and collective drive to change things for the better. The conversations were not just about what holds us back, but about how we move forward together.

Leadership, flexibility and systemic change

Women doctors bring unparalleled value to healthcare, not only as clinicians but also as compassionate and effective leaders. Yet they remain underrepresented in senior and strategic roles across the NHS. This loss of talent is not only unjust, it's economically and clinically detrimental.

The panel's statement calls for more specialty training posts and greater flexibility in how doctors train, shared parental leave structures that incentivise uptake by fathers, changing cultural expectations, institutional support for returning doctors, including practical provisions for breastfeeding, protected teaching time, and support staff.

Why this matters to cardiothoracic surgery

Cardiothoracic surgery remains one of the least gender-diverse specialties. The pathway is long, intense, and often incompatible with current system structures. At WiCTS, we recognise that without systemic reform, many outstanding future surgeons will be lost to our specialty before they even begin.

We must address culture, not just logistics. That means countering damaging stereotypes, ending dismissive advice, and encouraging supportive training environments that embrace difference rather than fear it.

How WiCTS is working to build a more supportive specialty

At Women in Cardiothoracic Surgery (WiCTS), we've been actively responding to these challenges with tangible initiatives that are already making a difference.

One of our proudest achievements has been launching the first formal mentorship scheme in UK cardiothoracic surgery history – the WiCTS 'Lift as you climb' programme, established under the leadership of Miss Karen Booth. This mentorship network was created specifically to support women in navigating their careers, building confidence, and opening doors.

This work culminated in our recently published paper in the Journal of Cardiothoracic Surgery, which offers some truly encouraging insights[1]:

90% of participants said they would recommend the scheme to colleagues.

The majority of mentees met important personal and professional goals they identified at the outset, with mentoring often delivered through flexible, virtual platforms – a model that suited diverse lifestyles and workloads.

Women especially highlighted the value of mentorship relationships that recognised the unique challenges faced as a minority in this field.

The study also reinforced that mentorship is not just "nice to have", it's a critical tool for unlocking maximum career potential, supporting work-life balance, and even mitigating burnout, which has direct implications for patient safety.

The Power of Male Allies

As we strive to reshape the culture of our specialty, it's clear that this cannot be the work of women alone.

Male allies are vital, to champion fairness, to sponsor talented women into leadership opportunities, to challenge outdated norms and microaggressions, and to actively build the kind of inclusive workplaces that benefit everyone.

By walking this path side by side, we will go far. Together, we will build teams that are more resilient, creative, and better equipped to deliver exceptional patient care.

Our vision at WiCTS is clear:

A specialty where mentorship and sponsorship are embedded into training and career development, not left to chance.

Where flexible pathways are not an exception but an integral feature, allowing every surgeon to thrive through different stages of life.

Where diverse role models inspire the next generation and leadership truly reflects the workforce it represents.

This is not just about equity for women doctors, it's about making sure cardiothoracic surgery continues to attract, develop, and retain the very best people for the ultimate benefit of our patients.

Conclusion

We at WiCTS stand firmly behind the statements issued at the MWF conference. We urge all members of SCTS to reflect, engage, and take active steps, whether through mentoring, sponsoring, or simply by making our day-to-day interactions more respectful and inclusive.

Let cardiothoracic surgery be known not only for its technical brilliance and pioneering spirit, but also for leading the way in creating a specialty that values, supports, and harnesses the full potential of every talented surgeon. ■

[1] Lee M, Layton GR, Belcher E, Harrington D, Hardman G, Evans B, Moorjani N, Booth K. An environmental scan of current mentorship: fostering the next generations in cardiothoracic surgery in the UK. J Cardiothorac Surg. 2025 Mar 12;20(1):150. doi: 10.1186/s13019-024-03240-6. PMID: 40075513; PMCID: PMC11900643.

Bulletin Report from the SCTS representative to the Royal College of Surgeons of England Council

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

Narain Moorjani (right) and Rana Sayeed at the Royal College of Surgeons, London

I would like to start by congratulating Rana Sayeed, who has been elected as my successor to the post of SCTS Representative on the Royal College of Surgeons (RCS) England Council on a 4-year term, commencing on 1st July 2025 until 30th June 2029.

The Royal College of Surgeons of England Council

The RCS Council is a group of elected surgeons who represent the diverse interests of the College's membership. The surgeons are elected either directly from the RCS membership or as representatives of the ten surgical specialty associations. They are responsible for setting professional standards, influencing policy and providing strategic leadership for the surgical profession. The Council is the delegated authority for all matters relating to professional policy and membership, and they meet regularly to discuss and guide the College's work. The Council acts as the governing body of the College, working to advance the surgical profession and improve patient care.

Development of a separate SCTS Representative on RCS Council

Previously, the SCTS President represented the Society on the RCS England Council but over the past few years it became clear that the SCTS was an outlier. Prior to the change, 9 out of the 10 Surgical Specialty Associations (SSA) Representatives on the RCS Council were not the President. The SCTS was the only exception by having their President act as the SSA Representative on RCS Council.

"It is reassuring that the SCTS have been very active and vocal to support similar initiatives within cardiothoracic surgery and continues to build on its EDI strategy. The importance of this work to attract and support the brightest individuals to our specialty cannot be underestimated."

In addition, 8 out of 10 Surgical Specialty Associations Representatives on RCS Council were nominated following a specific election process for the post. The SCTS again was one of the exceptions by having a representative on Council without election.

The reasons stated by the other Surgical Specialty Associations for not having their President as their SSA Representative on RCS Council were:

a) diversification of opportunities – ensuring that all the roles are not held by one person, thereby providing a diversity of opinion
b) ensuring the SSA Representative on RCS Council is specifically elected to that role
c) avoiding a conflict of interest
d) workload management – the SSA Representative on RCS Council role itself requires 15-20 days per year

In view of this, following circulation of a guidance document produced by the Federation of the Surgical Speciality Associations (FSSA), that had been approved by the President and Chief Executive of the Royal College of Surgeons of England, the SCTS sought to undertake a process where the SCTS representative to the RCS Council was elected specifically to that role by a transparent process, which was consistent with the other Surgical Specialty Associations. Following discussions at the SCTS Senior Executive meetings and the SCTS Executive Board, it was approved for the election of the new role of SCTS Representative to the RCS England Council to take over the role that was previously held by the SCTS President.

The SCTS representative on RCS Council election took place in Dec 2024 / Jan 2025, with results discussed and approved at the SCTS Senior Executive Meeting and SCTS Executive Board Meeting in Jan / Feb 2025. The results have been communicated with the RCS England, who have approved the nomination of Rana Sayeed as SCTS SSA Representative on RCS Council for 4 years, commencing on 1st July 2025 and completing his post on 30th June 2029. The timing of the transition between post holders takes place in July, in line with the RCS College year (that runs from July to July), which had previously been requested by the RCS England, and is consistent with the handover from previous SCTS representatives on RCS Council.

Over the last 3 months, a number of important topics have been discussed at the RCS England Council, which are relevant to the SCTS, including:

1. **Supporting neurodiversity in the surgical workforce**
   A presentation was given by Paul Sadler (Lead Specialty Dean for Cardiothoracic Surgery) stressing the importance of supporting surgical trainees with neurodiverse characteristics and how to make the most of their positive attributes. Moving forward, it will be important for the surgical speciality associations, SACs and Exam Boards to develop a strategy with this in mind.

2. **The Future of Surgical Training**
   The RCS England is in the process of drawing up a document that will be looking at how surgical training will be delivered over the coming years, so that it will contribute to the NHS 10-Year Plan, Long Term Workforce Plan and new National Medical Training Review. The SACs and SSAs, including the SCTS, will be asked to contribute to this project. Some key themes that have arisen include:
   a) A reliance on resident surgeons to provide service to the detriment of training.
   b) Lack of access to training in theatre.
   c) No allocated or protected time for teaching and training in job plans.
   d) Cost of training for resident surgeons.
   e) Low morale and burnout amongst trainees.
   f) Levels of recruitment and attrition from demographic groups known to be under-represented in surgery.
   g) Variable approach to the training and educational needs of Trust Appointed Doctors.
   h) Lack of workforce data with which to plan for future workforce needs.

3. **Royal College of Surgeons Census**
   The RCS census has been launched and will provide invaluable information for surgery in general but also for cardiothoracic surgery specifically, such for strategic workforce planning and advocacy on a national level. Unfortunately, it has had limited responses from Cardiothoracic Surgery. The SCTS have been asked to encourage engagement with the survey to obtain valuable cardiothoracic surgery specific information.

4. **Equality, Diversity & Inclusion (EDI)**
   The RCS England is running a number of EDI initiatives, including the Grassroots in Surgery scheme; Women In Surgery programme; Parents In Surgery portfolio; Mentorship programme; support to protect practitioners from sexual misconduct in surgery; and the Emerging Leaders programme.

It is reassuring that the SCTS have been very active and vocal to support similar initiatives within cardiothoracic surgery and continues to build on its EDI strategy. The importance of this work to attract and support the brightest individuals to our specialty cannot be underestimated to ensure a bright future for the specialty and ensure those from all backgrounds are given an opportunity to flourish in cardiothoracic surgery. The EDI and WiCTS sub-committees should be given all the support it can to further develop this important work.

It has been an honour and privilege to serve the SCTS on the RCS England Council over the past few years and I would like to wish Rana Sayeed all the best, as he commences his 4-year term on RCS Council, as I am sure he will do a fantastic job to represent the Society. ■

Development of a Decision Support Tool for screening in Thoracic Aortic Diseases: An update from the DECIDE TAD initiative

Riccardo Abbasciano (pictured), Hammersmith Hospital, Imperial College Healthcare & University of Leicester
Mark Lewis, Aortic Dissection Awareness UK & Ireland
Maria Pufulete, University of Bristol

The impact of thoracic aortic diseases (TAD) in a patient's life cannot be overstated. Apart from the clinical implication of having an aortic aneurysm, the diagnosis itself can lead to anxiety about the regular surveillance appointments and therapeutic strategies and uncertainty around the clinical scenarios that could present in the future. These impact on quality of life. Moreover, these diseases have a recognised familiar component and despite stronger recommendations to pursue cascade screening, uptake in the UK is low and unequal, as shown in our research.

Genetic testing's importance is increasingly recognised in TAD, as clear from the latest revision of the guidelines. Genetic findings can guide surveillance and decision-making regarding the management. The NHS panel currently in use for testing, includes genes that are critical to the structural integrity of the aorta, from pathways such as extracellular matrix components (e.g., fibrillin-1), TGF-β signalling regulators (e.g., TGFBR1/2), and smooth muscle contractility proteins (e.g., ACTA2). Timely interventions could be individualised, tailored to the patient's genotype and not exclusively on the size criteria of aneurysm. This in turn can potentially prevent acute aortic syndromes, which often incur at aortic sizes which are below current threshold for prophylactic surgery. Our national patient survey showed that only half of respondents (aortic dissection survivors) were offered genetic screening by their healthcare provider, despite their willingness to obtain it. All too often the burden to initiate the conversation around the potential genetic nature of the condition falls on the patient. Patients can struggle to initiate conversation with their relatives (and sometimes the primary care providers looking after them) about their disease and its genetic basis as a result of the lack of clarity from their initial appointment with clinicians in the aortic centres. This results in an insufficient and varied provision of imaging scans for family members, which are of vital importance especially in non-syndromic familial forms of TAD where there are no external signs of the disease.

DECIDE TAD, is a collaborative research programme between the University of Leicester and Aortic Dissection Awareness UK & Ireland (ADAUK&I), supported by the National Institute for Health Research (NIHR) Programme Grants for Applied Research.

The programme, which runs over the next five years, aims is to remove barriers

to access cascade screening for TAD and improve the uptake of screening by TAD patients and their relatives to prevent future aortic dissection. The programme was initiated by aortic dissection survivor Gareth Owens and Prof Gavin Murphy (BHF Chair of Cardiac Surgery at the University of Leicester), with a central team of five PPI partners: Anne Cotton (Chair of ADAUK&I), Mark Lewis, Lisa Skinner, Dr Gordon McManus and Dr Alison Prowle, who are all contributing to all aspects of research, including planning, design and dissemination.

This research initiative is currently in its first stage, the co-design process of a Decision Support Tool for TAD patients and their relatives, led by Dr Maria Pufulete (Associate Professor in Applied Health Research at the University of Bristol), Prof Alicia O'Cathain (Director of the Health and Care Research Unit at the University of Sheffield) and Dr Riccardo Abbasciano (NIHR Senior Research Fellow at Imperial College London and University of Leicester).

We gathered a wide panel of cardiologists, clinical geneticists, aortic nurses and patients and relatives' representatives, and produced two decision support tools (DST) for TAD patients and their relatives, explaining the benefits but also highlighting the uncertainties around genetic testing and cascade imaging tests in TAD. The DSTs are written in a language that is simple and inclusive, to reach under-served groups, and provide unbiased information, which will hopefully improve communication between families and their clinical teams and create a forum for shared decision making. Mark Lewis is leading the conversion of the DSTs into a digital tool that could, in the future, be integrated in the NHS digital infrastructure.

This ambitious project aligns with the Aortic Dissection Awareness UK & Ireland campaign "Think Aorta, Think Family", and is progressing well. We next plan to obtain feedback from a wider panel of patients and clinicians over the next seven months in order to optimise the DSTs, with the aim of having a beta version of the Digital DST in time for the Aortic Dissection Awareness Day 2025, which will be held in Leicester on the 18th September 2025. Starting from 2026, we plan to test the effectiveness of the DST in a multicentre randomised controlled trial.

We invite anyone interested in collaborating on this project to contact us through the national patients charity (**https://aorticdissectionawareness.org/**) or via email at **decidetad@leicester.ac.uk**. **Proactive screening and prevention will empower families and saves lives!** ■

Demitted Roles

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

Role	Name
SCTS President	Narain Moorjani
SCTS Honorary Secretary	Rana Sayeed
SCTS Elected Trustee	Vipin Zamvar
SCTS Elected Trustee	Manoj Purohit
Intercollegiate Specialty Board Chair	Sridhar Rathinam
SCTS Education Secretary (Thoracic)	Elizabeth Belcher
SCTS Education Tutor	Michael Shackcloth

New Roles

Congratulations to the following ...

Role	Name
SCTS President	Aman Coonar
SCTS Honorary Secretary	Douglas West
RCS England Council Representative	Rana Sayeed
SCTS Fund Raising Development Lead	Cha Rajakaruna
SCTS Fund Raising Development Lead	Giuseppe Aresu
SCTS EDI Co-Chair	Vipin Zamvar
Intercollegiate Specialty Board Chair	Elizabeth Belcher
SCTS Education Secretary (Thoracic)	Michael Shackcloth

Congenital Heart Research Network in UK and Ireland

Nigel Drury, Academic Consultant, Birmingham Children's Hospital,
Director of the Congenital Heart Research Network
On behalf of the Congenital Heart Research Network Executive Committee

As described in a previous edition of *the bulletin* (Issue 13, January 2023), 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). This was a collaboration between SCTS, British Congenital Cardiac Association (BCCA), James Lind Alliance, and two national charities, Children's Heart Federation, and Somerville Heart Foundation.

Participants at each of the final workshops independently agreed two final Top 10 lists of priorities, one child/antenatal and one adult CHD. 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. Many of these priorities encompass holistic outcomes, looking beyond early mortality to improve the quality of survivorship and reduce the impact of living with CHD, and whilst diverse methodologies will be required to address them, many are well suited to multi-centre clinical trials.

Most PSPs publish their Top 10 priorities and leave it to the wider community to address them. However, given the scarcity of research collaborations between CHD centres in the UK and Ireland, we felt strongly that we should use the priorities as a platform to bring the community together, to develop more collaborative research for the benefit of all. This led to the publication of *'Transforming collaborative research: a national strategy to address the James Lind Alliance priorities for children and adults with congenital heart disease'* in July 2023, which was endorsed by SCTS, BCCA, and national charity partners, and supported by NHS England Specialised Commissioning and the national CHD Clinical Reference Group.

The central objective of the strategy was the establishment of the Congenital Heart Research Network, a UK and Ireland collaborative network for multi-centre studies in congenital and paediatric inherited & acquired heart disease, focusing on clinical trials and other studies that address the most important questions and have the potential to

Congenital Heart Research Network Development workshop, May 2025

change clinical practice to improve clinical care and outcomes. This will be supported by a national CHD patient and public involvement and engagement (PPIE) group, comprised of patients, parents, carers, and charity members with lived experience or affected by CHD, to actively contribute through all stages of the design, conduct, and reporting of the research.

Following discussions, the Network was formally adopted as a subcommittee of BCCA, with oversight and governance provided by BCCA Council, and administrative support from the British Heart Foundation Clinical Research Collaborative (BHF-CRC). An Executive committee was formed to oversee the running of the Network with an elected Chair position, an appointed Director, and representation from BCCA (President, Scientific Secretary), SCTS (Congenital Research Lead), NICOR (NCHDA Clinical Lead), patients/parents (Chair, national CHD PPIE group), charities (CEO, Children's Heart Federation), nursing and allied healthcare professionals, and additional members as needed, to provide representation across paediatric and adult CHD. The committee agreed terms of reference, a mission statement and objectives, as shown in the table.

To shape the development of the Network, we organised a one-day workshop at the Royal Society of Medicine, London on 14 May 2025, jointly funded by the BHF-CRC and a generous donation from the Miskin family. This event brought together key members of the paediatric and adult congenital cardiac community from across the UK and Ireland, including healthcare professionals, researchers, national charities, funders, and other stakeholders, to establish the Network's direction and initiate discussions on addressing the priorities. To learn from the experiences of others, we were joined by Prof Gavin Murphy, who described the journey from the Adult Cardiac Surgery PSP to developing the UK National Adult Cardiac Surgery Clinical Trials Initiative, and virtually by Dr Kristin Burns, Programme Lead at the US National Heart Lung and Blood Institute, on 20+ years of the Pediatric Heart Network in North America.

In breakout groups, we discussed aspects of the Network including project development, authorship and publications, research training, and PPIE. The feedback from this session will be used to inform development of a Manual of Operations, which will describe the Network's strategy, structures, and processes, including clear terms of reference to encourage all interested parties to participate on an equal footing with appropriate recognition. The draft document will be widely consulted on across the community over the summer.

In the afternoon, there were quick-fire pitches of studies in late phase development that may benefit from Network involvement; the selected talks focused on imaging in coarctation, pulmonary lymphangiectasia in hypoplastic left heart syndrome, and several projects related to pulmonary valve replacement, including a national registry and a pragmatic, multi-centre clinical trial comparing valve prostheses. This was followed by a second breakout session, in which participants were grouped based on which of the priorities they were most interested in, to facilitate discussions on building collaborations and addressing the priorities, as a primer to forming Clinical Study Groups to take these forward.

The next steps in establishing the Network include electing a Network Chair, developing and finalising the Manual of Operations, building on discussions to address the priorities, identifying research training needs of the CHD workforce through a national survey, and setting up and recruiting members to the national CHD PPIE group. Once established, we will hold biannual Network meetings with a standing agenda including a network update, present current studies, discuss recently completed studies, and pitch new ideas.

In summary, the priorities provide a platform for conducting the research that matters most, whilst the Network will provide structures to support investigators to translate the priorities into research questions and funded studies. Together, these provide a unique opportunity to transform collaborative research in UK and Ireland for the benefit of the whole community. The success of this venture will be determined by its ability to deliver multi-centre studies, integrate participation in research into routine clinical care in CHD, develop the next generation of clinical researchers, inform international clinical guidelines, and ultimately deliver better outcomes for patients and their families.

For more information, please contact **nigel.drury@nhs.net** ■

Congenital Heart Research Network: mission statement and objectives.

Mission Statement
1. To improve the health outcomes and lives of those affected by congenital and paediatric inherited & acquired heart disease.
2. To support and conduct high-quality, multi-centre collaborative research to drive evidence-based care.
3. To involve patients, families, and charities in all aspects of the research.
4. To improve the research knowledge and skills of the CHD workforce.
Objectives
1. To bring together all CHD centres in the UK and Ireland in an open, inclusive, equitable and transparent collaboration for research.
2. To provide a framework to support investigators to develop and lead multi-centre studies, primarily clinical trials but including other research such as prospective observational studies, analyses of routinely collected data, systematic reviews and surveys of practice.
3. To facilitate patient and public involvement and engagement, with representation and integration through all stages of the research lifecycle.
4. To work with other national organisations to encourage better use of routinely collected data for CHD research.
5. To develop a platform of training to enhance the research knowledge and skills of the CHD workforce, including trainees to become the next generation of research leaders.

SCTS Transplant Education Lead Report

Espeed Khoshbin, SCTS Education Transplant Lead,
Consultant Cardiac and Cardiothoracic Transplant Surgeon, Harefield Hospital

Maintaining standards and quality assurance has always been a priority of the SCTS and under the remit of the SAC. Based on an earlier national survey of transplant training in the UK, there were concerns raised regarding maintaining general cardiac skills while in transplant training. Fellows "felt that they had to compete with other trainees for general theatre exposure".

Peri CCT National Fellowship in Transplantation

In 2009, the Joint committee for higher surgical training recognised the need to train transplant surgeons to meet the demands of the NHS. A transplant specific training was developed that recruited national trainees interested in a career in transplantation. The Fellowship was partially funded by NHS England. Although the fellowship did not guarantee appointment to a consultant position following training. In 2021, we reported that as much as half the trained transplant surgeons secured a consultant position within 6 months of leaving the fellowship.

The New Advanced National Transplant Training

Lack of cardiothoracic transplant surgeons remains a global problem. The highly demanding and unsociable lifestyle makes this career attractive to only a few inspired and skilled individuals. Many UK transplant surgeons have left to the US in search of better job satisfaction. In 2024, together with the SAC, we began to reform transplant training in the UK. Learning from our experience with the Peri CCT Fellowship, supported by the SCTS education sub-committee, we developed a training curriculum specific to transplant training. The Fellowship and its curriculum were reviewed by the transplant community, approved by the SCTS executive and quality assured by the SAC. Full funding (100%) was approved for two fellows by NHS England for a period of 18 extendable to 24 months. This will allow the New Fellowship to be an additional post, hence the Fellows will be supernumerary to the fleet of transplant fellows. The new Fellowship is no longer exclusive to NTN trainees but also open to the alternative pathway trainees in final stages of their CSER application process. The trainees should have passed the FRCS (CTh) or have equivalent qualifications. Candidates should be eligible to be on the GMC specialist register at the time of completion of their Fellowship.

"SCTS Advanced Fellowships will provide high-quality, prestige, and quality-assured advanced training in Cardiothoracic Transplantation and Mechanical Circulatory Support (CT-MCS) in the UK".

Fellows will be appointed through competitive interviews, against the pre-defined person specification. Posts will also be open to recently appointed consultants, senior trainees and Speciality and Specialist (SAS) doctors with a demonstrable interest in Cardiothoracic Transplantation. The successful candidates will have an option to split their Fellowship between two recognised training centres.

Applicants should be compliant with the following requirements: a) be fully registered with the GMC and have a licence to practise (UK Fellows) or be registered with the Medical Council in Ireland (Republic of Ireland Fellows); b) have successfully passed the Intercollegiate Specialty Board Examination; c) have achieved level end of Phase 2 competencies in all the Capabilities in Practice (CiPs) or equivalent; d) have been awarded an outcome 1 at ST5 ARCP or have a minimum of 3 years' experience at registrar level within the speciality.

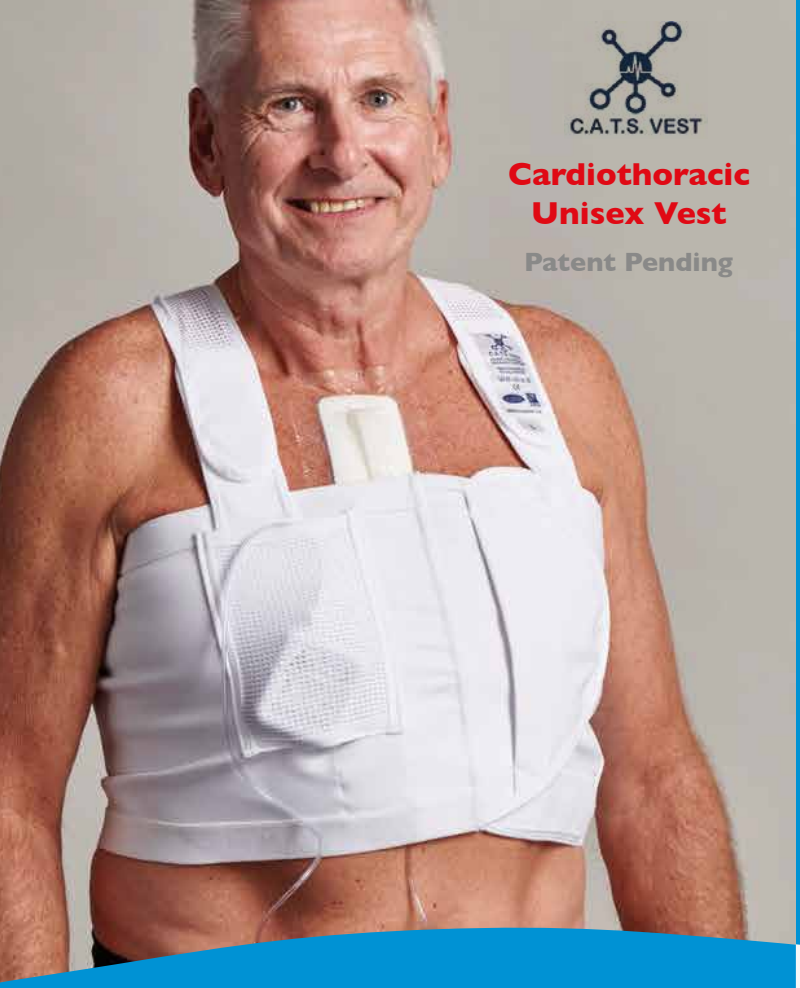
End Point of Fellowship

All elements of work in Cardiothoracic Transplantation and Mechanical Circulatory Support will be supervised. The level of supervision will be appropriate according to the experience of the Fellow, the clinical exposure and the case mix undertaken. As training progresses, Fellows will have the opportunity for increased autonomy, consistent with safe and effective care for the patient.

The Fellows would also have the opportunity to attend specific courses and conferences essential for their development. The Fellow should achieve level 4 competency in all categories specified in basic knowledge and clinical judgement, being able to evaluate end stage heart and lung failure surgical conditions and formulate appropriate management plans, including emergency cases. During the early training, Fellows should be signed off by the NORS team as being level 4 competent in organ retrieval and should obtain NHSBT registration certification. Fellows should perform routine cardiac/thoracic procedures depending on their speciality on a weekly basis to maintain general skills in cardiothoracic surgery. This has been particularly emphasised by the SAC. Fellows should therefore be allocated to a general cardiac/thoracic firm during their fellowship. The Fellows should demonstrate progress in their general surgical skills as well as undertaking a minimum of 20 index transplant related procedures either independently or under supervision by the end of their Fellowship. These include heart and lung transplantation as well as insertion of short to long term mechanical assist devices.

The Fellowship will not be a guarantee to a substantive consultant position in transplantation, but successfully completed candidates will be fully trained and certified transplant surgeons that could meet national demand for this speciality.

I would like to thank Tim Jones SAC Chair, Elizabeth Belcher SCTS Education Subcommittee Co-Chair, Steve Clark, and Steven Tsui past peri CCT Fellowship directors for their support of the new advanced transplant fellowship. ■



C.A.T.S. VEST

Cardiothoracic Unisex Vest

Patent Pending

The C.A.T.S™ vest and the BHIS™ bra have been designed in the UK by clinical experts in cardiothoracic and surgical site infection prevention. Both post-operative chest supports have shown to provide support and comfort to aid patient rehabilitation.

C.A.T.S™ CARDIO ADJUSTABLE THORACIC SUPPORT VEST

- Easy to apply, adjust and remove with adjustable shoulder straps and front opening.
- Acts as a light splint to aid early patient recovery and mobility.
- Allows easy access for wound inspection.
- New unique pocket design to accommodate devices e.g., telemetry with exit hole for wires, or battery pack for topical negative pressure dressings.
- Environmentally friendly with low carbon miles, manufactured in the UK.

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- Lateral side support panels designed to protect the cardiac incision.
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- Two way stretch to accommodate fluid weight gain associated with cardiac surgery.
- The BHIS bra patented design focuses on lateral support instead of conventional compression, offering uncompromised respiratory comfort.

The C.A.T.S™ vest and the BHIS™ are both competitively priced and available to order on the NHS Supply Chain.
Product training and support material provided by CUI International.

All enquiries E: lisa.tate@cuiwear.com

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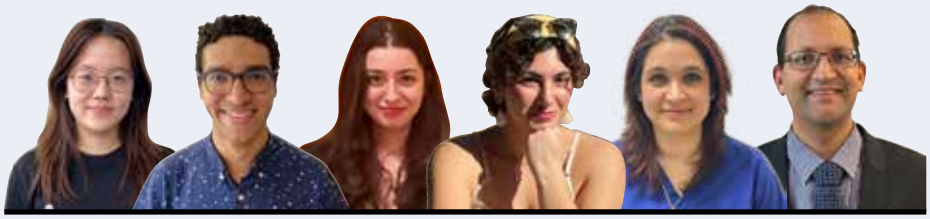
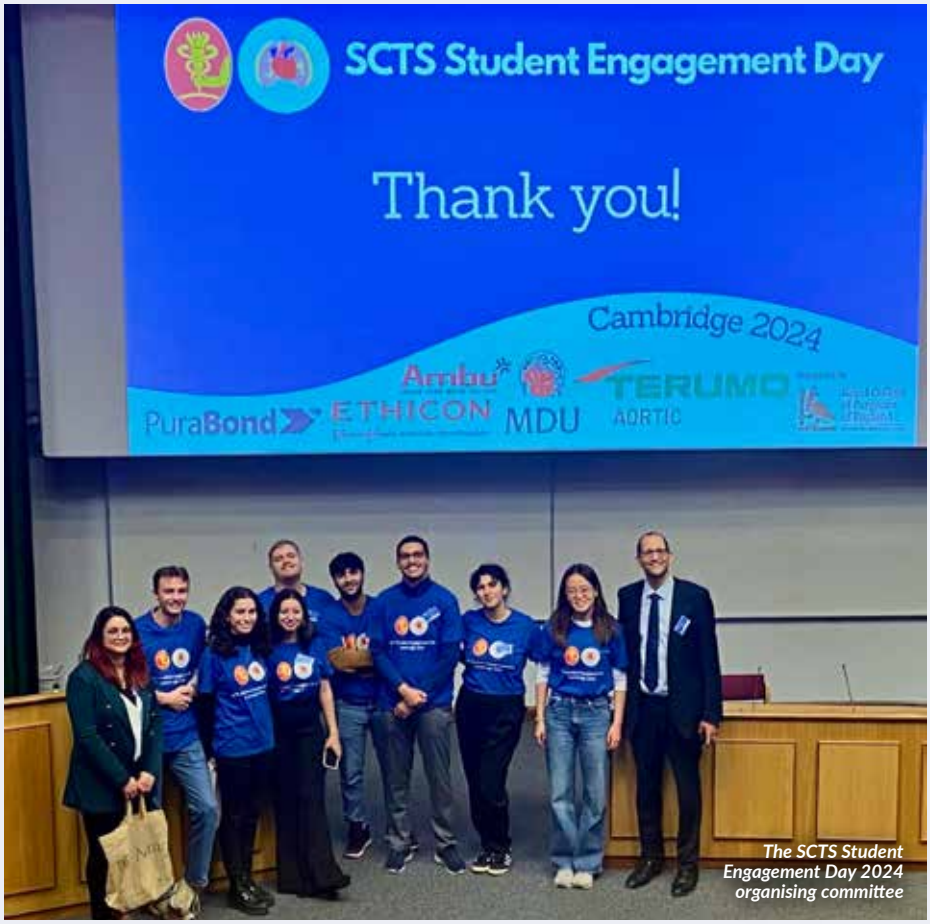
Inspiring Future Leaders – Highlights from the SCTS Student Engagement Day 2024

Sarah Guo, 5th Year Medical Student, University of Cambridge
Amro Sayed Fadel Ibrahim, 5th Year Medical Student, University of Cambridge
Nihal Sogandji, 6th Year Medical Student, University of Cambridge
Esther Abelian, 6th Year Medical Student, University of Cambridge
Miss Rushmi Purmessur, ST7 Cardiac Surgery Trainee, Royal Papworth Hospital, Cambridge
Mr Jason Ali, SCTS Student Education Co-Lead, Consultant Cardiothoracic Surgeon, Royal Papworth Hospital, Cambridge





The SCTS Student Engagement Day 2024 organising committee

The pathway to entry into cardiothoracic surgery training is notoriously difficult, exacerbated by the few ST1 positions available and requirement of early interest starting in medical school to build a strong portfolio. This can make the specialty a daunting one to consider, so is essential for engagement endeavours to start early, providing students with accessible experiences surrounding cardiothoracics and presenting approachable, inspiring and friendly figures to facilitate their interest and networking for future guidance and project opportunities.

This very principle was the driving force behind the Student Engagement Day 2024, a collaboration between SCTS and the Cambridge University Cardiothoracic Surgery Society, complete with talks, networking opportunities, practical workshops and awards. The event was made possible through the generous efforts of consultants, registrars, medical students and sponsoring organisations, who together, delivered a rich and varied experience for over 100 attendees. Special thanks go to Terumo Aortic, Medical Defence Union, Purabond, Ambu, Ethicon, and the Royal College of Surgeons for their invaluable support. The Student Engagement Day aimed to promote interest in the specialty amongst students ranging from sixth-form to university level, and facilitate the gathering of like-minded individuals, that they may find in each other future friends and collaborators.

The programme kicked off with an inspiring welcome by then SCTS President, Narain Moorjani, followed by an experienced array of consultant cardiothoracic keynote speakers. The talks took us through a whistle-stop tour of the specialty, including life beyond the day-job, pre-hospital emergencies, cardiac surgery in the developing world and a glimpse into the UK national pulmonary endarterectomy programme.

Farah Bhatti shared her reflections on integrating a demanding career within a colourful life, underscoring the critical

importance of building strong personal and professional support networks, echoing the ethos of the Student Engagement Day; that the future of the specialty depends on both technical excellence and fostering a culture of collaboration and inclusivity that extends well beyond the walls of the operating theatre.

Richard Steyn recounted his work directing the West Midlands Ambulance Service and solo pre-hospital response work, emphasising the profound value of having broad and flexible clinical skills as a surgeon, and highlighted the diversity and interdisciplinary nature of cardiothoracic careers.

Hassiba Smail gave unique insights into her humanitarian work with La Chaîne de l'Espoir, highlighting the clinical demands and profound ethical complexities of delivering cardiac surgery in resource-limited settings. This reminded us that global health work involves collaboration, respect for local expertise, and a thoughtful approach to the challenges of delivering care across diverse healthcare settings.

David Jenkins, director of the UK's national pulmonary endarterectomy programme, which has transformed the lives of thousands of patients and has gained international recognition, gave a powerful reminder that the reach of our work can extend far beyond individual operations – shaping services, advancing education, and supporting the evolution of clinical practice.

Hanad Ahmed delivered an insightful session on navigating the specialty application process. Drawing from his own experiences and current position as a trainee at Royal Papworth Hospital, he offered a structured overview on building a competitive portfolio. His session gave a sobering reminder of how success in this field relies on mindset and finding motivation in the process itself. For many in the audience, it was a valuable lesson into the resilience and passion required to thrive in a demanding yet deeply fulfilling career.

The medical school application session, catered to sixth formers, provided a chance for an honest conversation about the application process, motivations to enter medicine, life as a medical student, and challenges facing doctors. It offered candid advice from medical students who had relatively recently been through the same journey and highlighted that the first step towards this specialty starts with developing the traits, skills and awarenesses shared between all medical specialties.

The abstract competition welcomed entries on cardiothoracic case reports and audits/QIPs, providing an opportunity to win prizes celebrating student-led research. We received a large number of high-quality submissions, graded based on originality, rigour and relevance. Authors of accepted abstracts presented their posters to a select panel of judges and other delegates, providing valuable networking opportunities for students with shared interests. Congratulations to Akmal Irfan and Benjamin Chapman, who placed first and second in the case report competition, and Natasha Bocchetta and Olivia Heron, who placed first and second in the Audit/QIP category.

The afternoon's workshops offered a valuable opportunity for hands-on exposure to key areas of cardiothoracic surgery through a circuit of specialty-focused stations, fostering both cardiac and thoracic skills through basic suturing, coronary anastomosis, VATS and bronchoscopy. Case-based discussions rounded off the afternoon, challenging students to think like surgeons as they worked together through real-world scenarios under the guidance of senior trainees and consultants, nurturing a strong sense of community, reflected in the energy and commitment of everyone involved. Each station was led by experienced surgeons, creating an environment where students could learn how to perform key tasks and understand their clinical significance and context.

The key message of the event is reflected in the process of its creation. None of what happened would have been possible without the consistent and engaged teamwork of a large number of people, all focused on a common goal. This required generous support and encouragement between colleagues and a collaborative spirit both in the run-up and on the day. Similarly, the challenges faced by current students, generally in medicine but also specifically in the path towards cardiothoracics, can be addressed and overcome if we work together. Finding a group of like-minded people (as many may have done during this event), with whom you can embark on this journey with, will undoubtedly lift everyone involved and bring each person's goals much closer, regardless of their difficulty. The emphasis on collaboration over competition is not only for this stage of education, but a helpful and constant rule to live by and a powerful mover of the very teams that students will inevitably be working in, whether in the clinic, ward or theatre. ■

Students in action in coronary anastomosis workshop using Arroyo simulators

Endobronchial Procedure Training – Opportunity of a Lifetime?

Joyce Chan, FRCSEd, Associate Consultant
Aliss Chang, FRCSEd, Resident Specialist
Clarence Chan, MRCSEd, Specialist Registrar (Year 1)
Rainbow Lau, FRCSEd, Consultant & Honorary Associate Professor
Calvin Ng, MD, FRCSEd, Environmental Foundation Professor of Thoracic Surgery & Honorary Consultant
Division of Cardiothoracic Surgery, Department of Surgery, Prince of Wales Hospital, Chinese University of Hong Kong

"If you don't take change by the hand, it will take you by the throat."
Winston Churchill

Since the early 2010s, endobronchial procedures for lung cancer have embarked upon therapeutic intent rather than diagnostic alone. With the integration of various imaging adjuncts, for example real-time fluoroscopy, digital tomosynthesis, cone-beam computer tomography (CBCT), and radial endobronchial ultrasound (EBUS), the accuracy of endobronchial navigation and nodule localisation is further improved. Such is further facilitated by the advent of transbronchial access tools, greatly expanding the scope of endobronchial therapies into periphery of lungs. Since 2018, robotic bronchoscopic platforms utilising electromagnetic navigation (EMN) or shape-sensing technology came into play, further improving scope stability, depth of accessible bronchial tree, boosting the diagnostic yield to the range of 80%-90% and allowing possibility of precise treatment to small peripheral lung nodules. Various forms of endobronchial therapies have been described, including the use of thermal energy (radiofrequency, microwave and cryotherapy), electroporation, intra-tumoural injection of therapeutic agents, to name a few.

Our institute became an early adopter of endobronchial therapies for peripheral tumours in the hybrid theatre in 2019 (Figure 1). EMN-guided transbronchial microwave ablation was performed for early lung cancers and lung oligometastases, providing an alternative treatment option other than surgery and stereotactic radiation therapy, especially for frail patients who cannot tolerate more invasive approaches (Figure 2). Analysis of 260 nodules ablated over more than 5 years showed that the technique is safe and feasible, with low complication rate (pneumothorax 3.6%), short hospital stay (mean of 1.65 days), and good mid-term local control rate (recurrence rate currently at 6.3%). Concurrent pulsed electric field delivered endobronchially with systemic immune checkpoint blockade also offers potential of abscopal effect for treatment of both local and systemic disease. Endobronchial delivery of nanoparticles have also been described to increase the efficacy of radiotherapy or facilitate photodynamic therapy. With these encouraging results, transbronchial therapies are rapidly gaining momentum and the volume of procedures is expected to increase exponentially in the coming years.

Figure 1

Endobronchial Procedure Training – Current Status

Traditionally, endobronchial diagnostic procedures were performed by pulmonologists, while thoracic surgeons focused on surgical resection. However, in the recent decade, the border between diagnostic and therapeutic has blurred, and surgeons have been performing more and more endobronchial procedures. A select few surgeons in the US have even undergone thoracic surgery

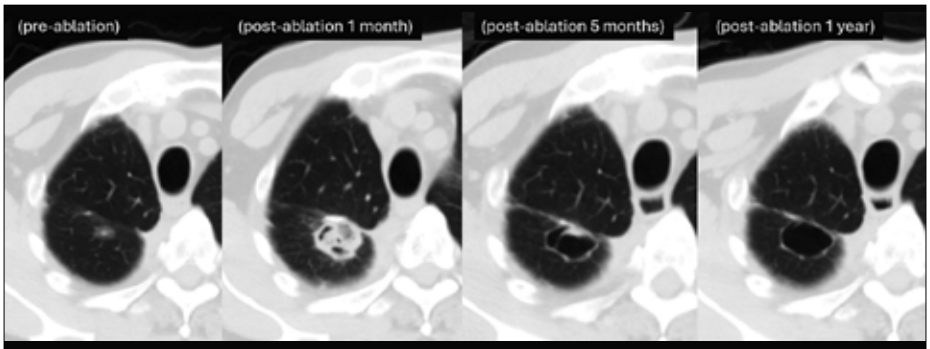


Figure 2

training curriculums that encompass surgical and interventional pulmonology training, qualifying as double fellows. Indeed, from a technical point of view, the entrance threshold for transbronchial procedures is not too high for surgeons, as they have a good grasp of pulmonary anatomy from their daily surgical practices, and usually possess the dexterity and patience required for precise manipulation through minimally invasive surgery (Figure 3). In our institute, even our first year trainees are trained to perform transbronchial procedures under supervision, as the learning curve is considerably less steep and the risks lower than performing a video-assisted thoracoscopic lobectomy. For younger generation Y and Z trainees, when first introduced to robotic bronchoscopy, the familiarity of the Xbox-inspired controller was nostalgic. The challenges lie not just within the identification of tissue planes or delicate tissue handling as in traditional surgery, but also the ability to manipulate devices through narrow airways to reach deep targets, akin to treasure hunting with a remotely controlled robot in underground winding tunnels. In many ways, our tech-savvy successors hold great potential for mastery of these procedures. Nevertheless, a stepwise approach to endobronchial procedures is encouraged for trainees, starting with simple flexible bronchoscopic diagnostic procedures, progressing to navigational bronchoscopy dye-marking nodule localisation, biopsy, simple ablations with bronchus sign, and eventually the ablation of complex lesions. Such approach was implemented in our institution, as we started with EMN bronchoscopic dye marking first in 2013, when we first started our hybrid theatre surgical programme. Decision making may be an even more important aspect than the technical know-how, as there are many nuances and fine techniques that could only be learnt through observing and assisting numerous procedures.

Figure 3

Endobronchial Procedure Training – Future Perspectives

Lung cancer treatment is becoming increasingly complex, and the importance of hybrid treatment strategies (combined surgery and endobronchial intervention) is greatly underscored. We are currently experiencing a shift in the spectrum of thoracic diseases, as we manage an increasing number of smaller, subsolid or multifocal lung lesions in an aging population. There is also a paradigm shift in the philosophy of lung cancer management from treatment to "prevention", as studies have shown that lung adenocarcinoma progresses in a step-wise manner from pre-cancerous lesions to invasive tumours. Similar to the role of colonoscopy for removal of pre-malignant colonic polyps, transbronchial therapies may play an important role in prevention of progression from pre-malignant ground glass nodules. In addition, many patients have already had major lung resection previously, but have growing lung nodules in their remaining lungs, making lung parenchyma and function preservation important. Thus, the unlimited potential of endobronchial interventions must be embraced, a promising avenue for the many patients who cannot tolerate surgery, especially after extensive lung resections for multifocal lung lesions. Compared to lung resection, the spectrum and breadth of disease and patient populations we can treat will also be widened with endobronchial therapies, as it not only includes those with early or mid stage lung cancers, but also those with late stage disease seeking for systemic immunogenic and abscopal effects, or even non-cancerous pathologies for example, emphysema and interstitial lung diseases.

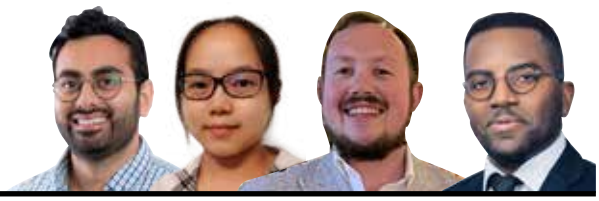
As cardiothoracic surgeons, we are at the front line of the battle against thoracic diseases. Our understanding of anatomy and ability to manage unexpected complications during endobronchial procedures provides us with a unique edge in this pivotal role. By mastering both surgery and endobronchial therapy, understanding their relative advantages and disadvantages as well as limitations, surgeons can provide the best hybrid bespoke therapy for their patients. Some thirty years ago, cardiac surgery dramatically changed with development of percutaneous coronary interventions and more recently valvular interventions performed by physicians. Perhaps as a lesson to learn, thoracic surgeons should not miss this once-in-an-era opportunity to master endobronchial therapies and expand the scope of our practices. Furthermore, endobronchial skills should be developed early – as early as the first year in training – instead of having to retrain after becoming fellows.

In the foreseeable future, we envision our thoracic fellows receiving training on surgical skills for tumour resection while practicing endobronchial skills using robotic-assisted technology to perform endobronchial ablation, brachytherapy, or intratumoral injection to smaller lesions. Mastery of all these skills will enable surgeons to develop personalised management plans for our patients, regardless of the complexity of their thoracic diseases. This is a role not just integral to the field, but also a responsibility we should all take pride in.

For those who wish to explore such technologies and are interested in a fellowship or training, please contact Prof Calvin Ng for more details at email: **calvinng@surgery.cuhk.edu.hk**. ■

Reflections from Toronto: Lessons for Lung Transplantation in the United Kingdom

Akshay J. Patel, Clinical Fellow in Lung Transplantation, University Health Network, Toronto
Lu Wang, Specialist Registrar, Cardiothoracic Surgery, Papworth
Marcus Taylor, Specialist Registrar, Cardiac Surgery and Transplantation, North West Deanery
Sean O. Bello, Consultant in Cardiac Surgery & Cardiothoracic Transplantation, Wythenshawe Hospital, Manchester



The clinical fellowship in lung transplantation at the Ajmera Transplant Centre, Toronto General Hospital (TGH), the largest and most active programme of its kind globally, offers a comprehensive experience. For anyone interested in thoracic transplantation, it is transformative. Beyond surgical exposure, the programme excels in clinical innovation, data-driven practice, and a deeply embedded research and training culture. For UK cardiothoracic surgeons fortunate enough to take part, the contrasts are sharp and increasingly instructive.

TGH performs over 200 lung transplants annually. Since achieving the world's first successful lung transplant in 1983, more than 3,500 transplants have been completed, with a median 30-day mortality of just 2.4%/year over the past decade. A key driver of this success is the programme's pragmatic approach to donor lungs: marginal organs are routinely assessed and, if viable, used. This is made possible by various cultural and institutional factors, but a significant player is the use of Ex Vivo Lung Perfusion (EVLP), a technology initially pioneered by Stig Steen from Sweden and subsequently industrialised at TGH.

Since 2008, over 1,100 lungs have been evaluated with EVLP at TGH, with approximately 66% of them eventually transplanted, accounting for nearly 40% of the total annual volume. EVLP allows real-time, extracorporeal assessment and reconditioning of donor lungs. Importantly, it is not used as a last resort but as a core component of clinical workflow. Its routine use is supported by provincial health funding, philanthropy, and industry partnerships, ensuring consistent delivery and facilitating innovation.

By contrast, lung transplantation in the UK has consistently low activity. Over the past decade, fewer than half of patients on the waiting list have received transplants. National transplant numbers peaked at 214 just before the COVID-19 pandemic, but have since averaged only 120 annually. According to National Health Service Blood and Transplant (NHSBT), of 1,880 consented donors last year, only 7% became lung donors. Of those meeting age criteria, just 15% of DBD and 5% of DCD donors were accepted for lung transplantation. These figures reflect a broader issue: around 60% of non-urgent patients on the UK list are still waiting, have been removed, or have died within three years of listing.

The barriers to donor utilisation in the UK are multifactorial. These include Intensive Care Unit (ICU) and theatre limitations, logistic challenges, stricter listing criteria, and ethical constraints such as the use of heparin or Medical Assistance in Death (MAID). There is also a prevailing risk aversion around using marginal organs, exacerbated by a lack of technology and trained personnel to support real-time evaluation.

A national, standardised EVLP platform remains absent in the UK. Many centres rely on bespoke, low-throughput systems. However, a step forward came with the Royal Papworth Hospital acquiring and deploying a commercial EVLP system (similar to Toronto's). This may stimulate wider adoption across UK centres, enhancing both organ utilisation and research capacity.

Another major contributor to TGH's high transplant volume is its routine use of 10°C lung preservation, allowing up to 24 hours of cold ischaemia. This offers flexibility in scheduling transplants, avoiding overnight procedures. Though Randomised Controlled Trial (RCT) data is pending, a 2023 multicentre retrospective study (Toronto, Vienna, Madrid) published in the New England Journal of Medicine supported its safety and efficacy. While the 10°C method is now more common in UK practice, its full potential remains untapped without widespread EVLP adoption.

The challenge is therefore not just technical but philosophical. In Toronto, the system is built to say "yes." Surgery runs around the clock, EVLP is deployed proactively, and trainees are actively involved, often as first operators. This high-volume environment supports the development of technical skill, clinical judgement, and academic engagement. In the UK, transplant surgery is centralised and technically restrictive. Many trainees receive only limited exposure, undermining morale and future recruitment into the specialty.

Demand for lung transplantation in the UK will rise. Traditional causes such as Chronic Obstructive Pulmonary Disease (COPD) and idiopathic pulmonary fibrosis (IPF) are being joined by emerging drivers like post-COVID fibrosis and vaping-related lung disease. The latter, especially in younger patients, is an evolving public health issue. With these trends, current UK capacity and infrastructure are unlikely to keep pace.

Toronto's model is not directly transferable to the UK. Healthcare systems, funding mechanisms, and regulatory landscapes differ. But its principles: strategic alignment, consistent innovation, and investment in people are universally applicable. Its success stems from deliberate choices: robust donor rehabilitation, integrated infrastructure, a research-driven environment, and a reliable pipeline of well-trained transplant surgeons.

Encouragingly, the UK has made some progress. Following the Organ Donation Taskforce's 2010 recommendations, the creation of the National Organ Retrieval Service (NORS) led to a 50% increase in donations. The 2021 Organ Utilisation Group (OUG) identified the need for wider access to innovations like EVLP. Royal Papworth's recent investment is a response to this call. The proposed development of Assessment and Recovery Centres (ARCs), where marginal lungs can undergo centralised EVLP assessment before redistribution, is another potential game-changer.

Yet other OUG priorities, particularly around workforce development remain under-addressed. In many UK centres, lung transplantation is delivered by two consultant surgeons. This narrow operating pool, exacerbated by COVID-related service disruption, has further reduced trainee exposure and impacted morale and retention. In contrast, Toronto's "consultant-led, fellow-delivered" model has sustained productivity and outcomes, even post-pandemic.

We must now ask the right questions: What would a modern lung transplant programme look like? Can it be sustainably funded? How can we reshape training pathways to ensure adequate operative exposure? What role could clinical–academic partnerships play in accelerating next-generation transplant technologies? And perhaps most importantly, can we reframe how we approach donor risk and recipient benefit?

The ability to attract and retain future transplant leaders is crucial. A 2019 UK workforce report showed that only 6% of consultant cardiothoracic transplant surgeons were under 40, while nearly half were over 50. Without addressing this demographic time bomb, strategies to increase transplant volume will remain theoretical. Many UK trainees have thrived in high-volume overseas fellowships, a testament to their ability and training pre-fellowship. There is no shortage of talent, only a shortage of structured opportunity.

As the national conversation continues around NORS reform and organ utilisation, lung transplantation must not be overlooked. The cost of inaction is counted not only in lost grafts, but in lives lost on the waiting list. Toronto has shown that excellent outcomes can be achieved, even with marginal donors, if the systems are in place to support them.

Meeting the UK's growing burden of end-stage lung disease will require system-level reform. Proven models exist. The task now is to adapt and apply them. ■

Obituary: Gareth Mervyn Rees

30.09.1935–20.10.2024, Consultant Cardiothoracic Surgeon, St Bartholomew's Hospital (1973–2000)

Steve Edmondson, Alex Shipolini & Rakesh Uppal
The Barts Heart Centre, St Bartholomew Hospital, London

Gareth Mervyn Rees "GMR", a distinguished Consultant Cardiothoracic Surgeon at St Bartholomew's Hospital from 1973 to 2000, played a pivotal role in transforming its modest cardiac surgery service into a major surgical centre. Together with his wife, Professor Dame Lesley Rees, he was instrumental in saving the hospital from closure following the 1992 Tomlinson Report, ensuring its legacy as a leading institution.

Born in Carmarthen, Wales, to a schoolmaster and a nurse, Gareth excelled academically and athletically, particularly in rugby. He pursued medicine at St Mary's Hospital, Paddington, following the well-trodden path of Welsh rugby players. His passion for rugby and his homeland endured throughout his life, with regular trips to Cardiff for international matches well into retirement.

After qualifying as a doctor, Gareth gained experience in various surgical specialties, including neurosurgery and orthopaedics, before focusing on cardiothoracic surgery. During his training at St Stephen's Hospital in London, he met his future wife Lesley, whom he married in 1968. Believing that cardiac surgeons should also be skilled physicians, Gareth earned his MRCP and later became a Fellow of the Royal College of Physicians (FRCP).

Gareth was among the first generation of UK cardiothoracic surgeons to receive formal training under eminent figures such as Lord Brock and Donald Ross. He also completed a fellowship in Portland, Oregon, with Albert Starr, a pioneer in valve surgery. His MS thesis on myocardial protection during aortic valve replacement, reflected his dedication to advancing surgical techniques.

As a consultant at Barts, Gareth quickly built a reputation as an exceptionally skilled surgeon with outstanding outcomes for patients. His expertise attracted referrals from across the country, including many high-profile individuals. A gifted teacher and mentor, he won Barts' Best Clinical Teacher award multiple times.

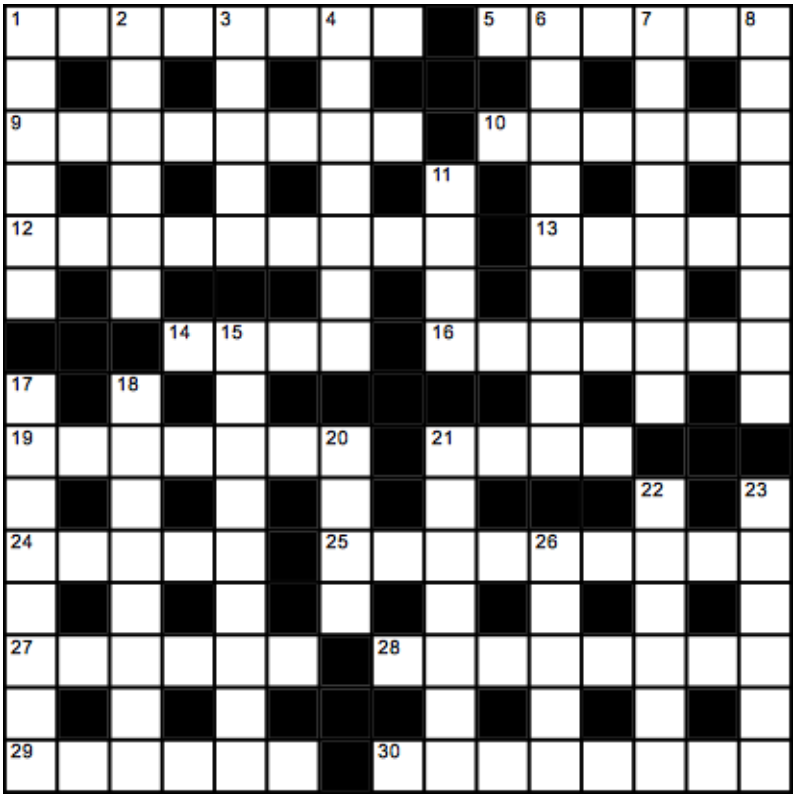
In addition to his clinical practice, Gareth collaborated with Roworth Spurrell and John Camm to establish Barts' surgical electrophysiology service. This pioneering programme offered innovative treatments for conditions like Wolff-Parkinson-White syndrome and ventricular tachycardia. Gareth's legacy extends beyond surgery.

His tireless efforts alongside colleagues – including his wife – were crucial in preserving St Bartholomew's Hospital during a politically challenging era. Their work ensured that Barts remains a thriving centre for cardiac and cancer care today.

Gareth is survived by his wife Lesley and his son Philip from his first marriage. ■

Crossword

Set by Samer Nashef



Across

1 St John's Muscat? (8)
5 Wild money mantra (6)
9 Pay grannies to dance (8)
10 Copyright fabric in drawer (6)
12 Daily help – great shakes (9)
13 Prime of plaster - and it needs topcoat to decorate (5)
14/21 Start to rebuild deep sea rig for oil producer (8)
16 Outlook if reported (7)
19 Flexible picture frames stand the test of time (7)
21 See 14
24 Wasting time in panic is a mistake (5)
25 Television's first box set somehow secures approval as educational material (9)
27 Rationale for *'About a Boy'* (6)
28 Invested in shares, our central fund (8)
29 Colouring said to be on the way out (6)
30 Money made from fashionable street development (8)

Down

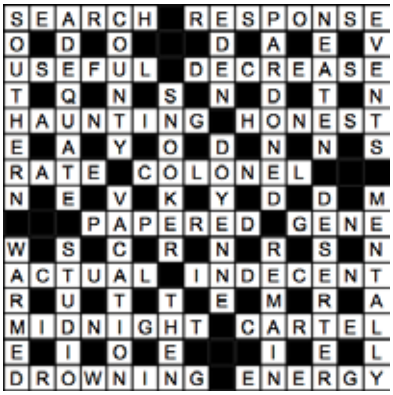
1 Rich bequests: half the boxes (6)
2 Fancy pedal pushers but no shades of lilac or violet? (6)
3 Object is to be slim by losing a little weight (5)
4 Carry fruit in bags (7)
6 Flyer for street opera out first (9)
7 Saving or robbery? (8)
8 Sorts men out from beasts (8)
11 Dogfood (4)
15 Time when a paper on Nero wrongly ... (9)
17 ... turned up a rewritten paper: 'finally Rome burned' (8)
18 Airs and graces singularly affected demeanour (8)
20 It's sharp, but not a sweet (4)
21 Building extension on abandoned square (7)
22 Rough ride, they say (6)
23 A lock-up claim (6)
26 O for a poet to be an ordinary man (5)

Please email solutions by 03/10/2025 to:

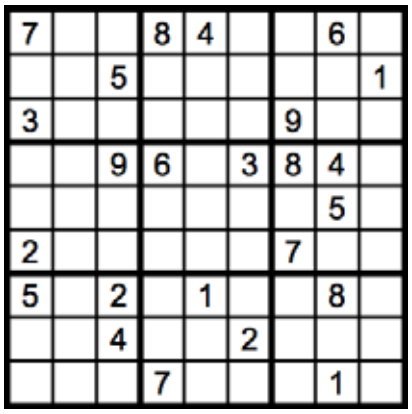
***emma@scts.org* or send to**
Emma Piotrowski, SCTS, 38-43, Lincoln's Inn Fields, London WC2A 3PE

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

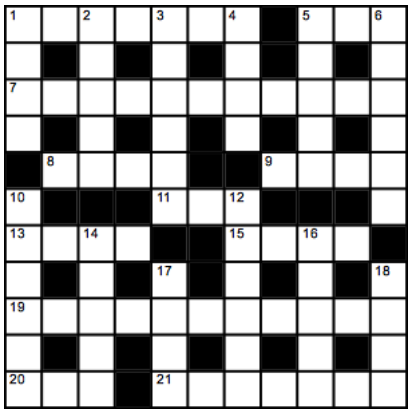
Congratulations to Bao Nguyen for winning the January 2025 Bulletin crossword competition (right) who chose a bottle of fine oil as his prize.



Sudoku



Quick Crossword



Across

1 Far-right ideology (7)
5/21 Imaging machine (3,7)
7 President (6,5)
8 Pay attention (4)
9 Tolerate (4)
11 Resort (3)
13 Win (4)
15 See 2 Down
19 Reform politician (11)
20 Still (3)
21 See 5

Down

1 Gradually vanish (4)
2/15 Pacemaker (5,4)
3 Small islands (6)
4 Chum (4)
5 Purplish colour (5)
6 Bring in (6)
10 Service business (6)
12 Capital of Turkey (6)
14 Bar of gold (5)
16 Remove liquid from (5)
17 Advantage (4)
18 Successor (4)

SCTS Annual Meeting 2026

Call for Abstracts

Abstract Submission Opens:
1 September 2025

Abstract Deadline:
5 November 2025

Registration Opens:
1 December 2025

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15–17 March
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