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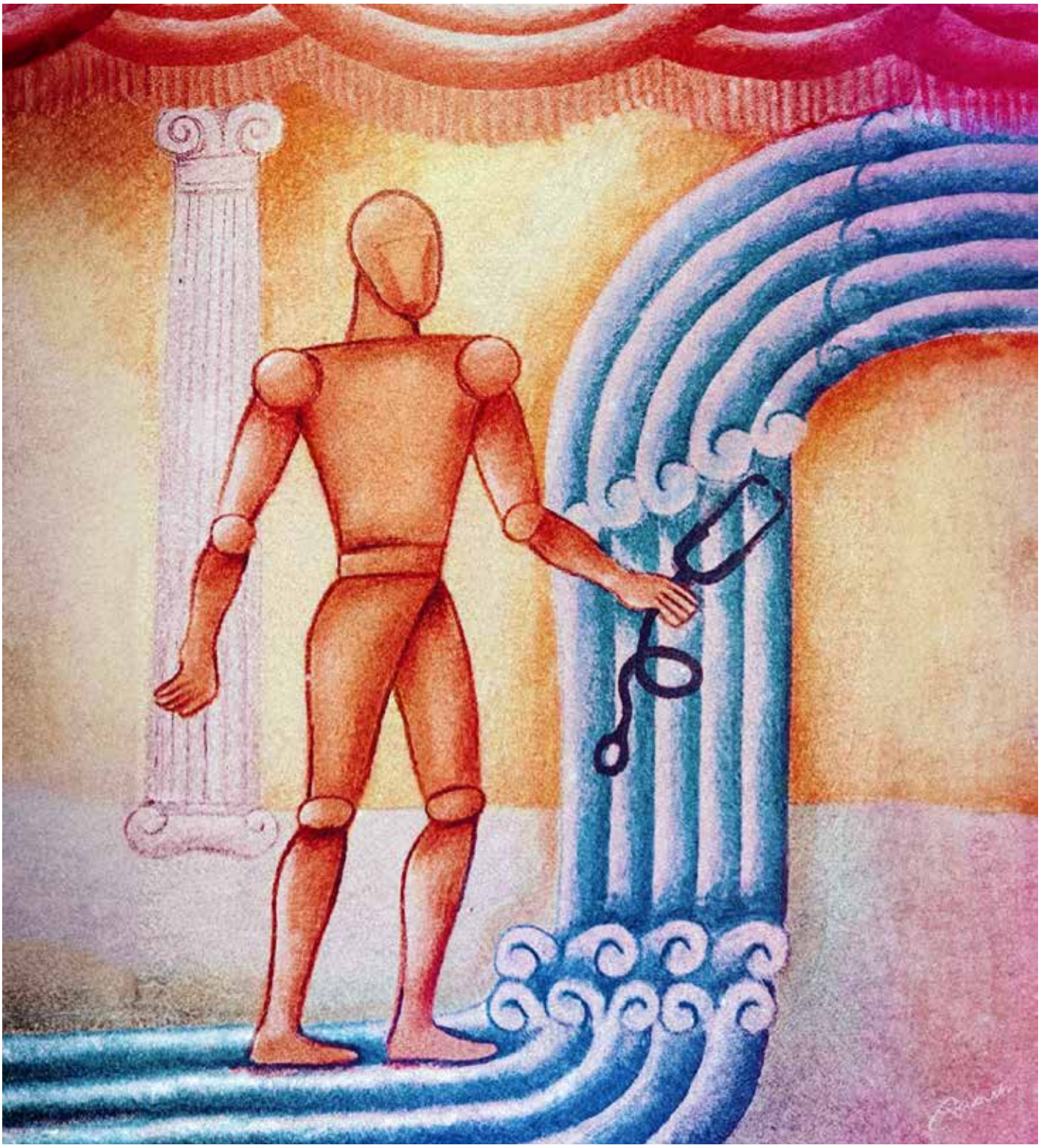
the bulletin

Society for Cardiothoracic Surgery in Great Britain and Ireland



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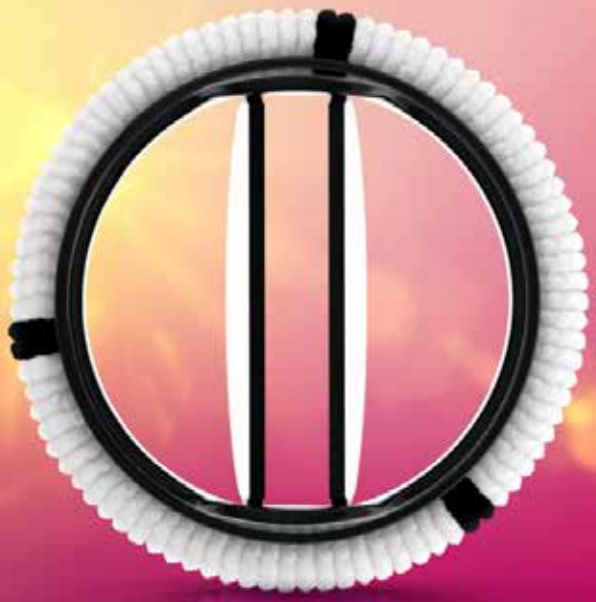

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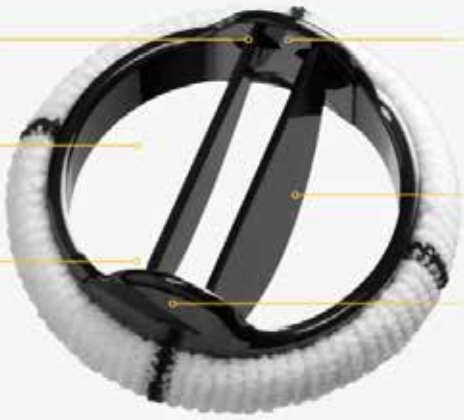

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From the Editor

Dionisios Stavroulias, Publishing Secretary, SCTS

In the final days of December, it is only natural to look ahead and wonder what the future holds. AI now touches almost every corner of our lives, and though experts tell us it should amplify our potential, many of us still question how AI will reshape our work and our sense of self.

James Lovelock's 2019 book Novacene has stayed with me. He argues that new forms of being will emerge from today's artificial intelligence systems: hyperintelligent cyborgs who will regard humans much as we now regard plants. Their arrival will mark the end of the Anthropocene and the dawn of the Novacene, a new evolutionary epoch. Lovelock embraces this future as a rational and ultimately beneficial development, one that serves the long-term destiny of the planet. We are scientists, and hence we tend to be rationalists. Yet, reading Stephen Hicks' Explaining Postmodernism, with its account of the rise of irrationalist philosophy – through thinkers such as Schopenhauer, Nietzsche, and Heidegger – left me reflecting on a genuine dilemma: if our current form of rationalism with its technoscientific progress is steadily steering us toward the Novacene, a post-human future, is it irrational – or deeply human – to defend humanity as the highest good?

Aman addresses a key aspect of our profession in his presidential report: the concept of risk and the balance between minimising it and avoiding risk altogether. The prevailing culture in our society is, in my view, one of "smooth sailing"; an expectation that things can only go well, and that when they do not, the surgeons are likely to be at fault. While errors do occur, it must be recognised that we are now operating on increasingly complex and unwell patients, undertaking procedures at the very limits of what is medically possible. Aman highlights how this mindset can hinder progress in our field, as we become reluctant to push boundaries for the benefit of patients due to fear of media criticism.

Doug West introduces his first Honorary Secretary report with an invitation for us, as a society, to grow by fostering long-term relationships within an expanded membership, ensuring that all members feel valued. He emphasises that we are now a society representing the entire team: surgeons, nurses, allied health professionals, and beyond. I believe the proposed Friends of SCTS initiative is a fantastic idea!

I read Ghaith's report on TADs with great interest, and I share his central point: it is essential that TADs have a clear pathway and proper guidance to support their progression toward consultant positions. However, he does not appear to acknowledge the absence of rigorous selection for this cohort of doctors who arrive in the UK – myself included – in stark contrast to the competitive NTN route. This difference in filtration contributes to the difficulties many TADs face.

And yet, as Ghaith notes, a significant proportion of consultants come from this very group of doctors, demonstrating that the opportunities are indeed there for those with the merit and determination to seize them.

Mark Jones' first SAC Chair report highlights the work that is taking place with recruitment and selection within the National Selection Board and 'run through' training. He also confirms that the Cardiothoracic Surgery Curriculum is being updated, with the new version expected to launch in August 2026. This revision is long overdue, as key major operations are not currently recognised as such in the existing curriculum.

The SCTS Education report is full of good news, starting with welcoming Mike Shackloth as our new Education Secretary in conjunction with Debbie Harrington. Our Fellowships and Collaborations continue to grow stronger. The courses offered to NTNs and TADs remain truly exceptional, in addition to the programmes running for medical students and NAHPs. None of this would be possible without the active and generous support of industry partners, especially J&J MedTech.

I read Andrew Parry's reports with particular attention, as this is a subspecialty continuously facing existential challenges. He reiterates that workforce retention over the past decade has been critical, with 52% of senior surgeons leaving the specialty; of those, 56% leaving the UK. I look forward to reading the 'What a Good Centre Looks Like' document on congenital cardiac surgery, which aims to secure support from fund holders for this important effort.

There are numerous developments on the thoracic side, as highlighted by Karen Redmond. The Pectus Working Group has been incredibly efficient, and the RESTORE trial even completed recruitment ahead of schedule. National guidelines from the Empyema and Trauma Working Groups are nearly ready, and the Airway, Diaphragm and Lung Volume Reduction teams are making great progress on regional guidance too. One thing I would personally like to see is the creation of a thymic working group – and hopefully we can make this happen. Looking ahead to 2026, two goals really stand out for me: launching the National Thoracic Registry in Belfast and publishing the Top 10 Thoracic Research Priorities. Both will be major milestones for the specialty and will help shape the direction of thoracic surgery for years to come.

This was the last Communications Report from Sri Rathinam. The Newsletter, From the Chest, is one of the many projects he has delivered over the years. I would like to thank him for all his hard work throughout his tenure, and on a personal note, for the generous support he has provided me in my role as editor.

Doug's report on the first year of the thoracic NCIP, together with Nathan and Ram's presentation of the 2023–2024 National Returns Data, highlights several encouraging trends. We are seeing a significant drop in mortality for both lobectomy and pneumonectomy, along with a remarkable rise in the proportion of cases performed robotically.

By the time this edition is published, the Autumn Budget will have been presented. RCS England is urging the government to give NHS trusts greater freedom to invest in expanding and modernising their facilities. I believe we should add our voice as a Society: increasing capacity is crucial for meeting targets, reducing waiting times, and ensuring patients receive timely care, a point I wholeheartedly support. I very much look forward to seeing you all at our annual meeting in Belfast.

Once again, this edition is packed with fantastic articles, be sure to read it from cover to cover!

Lastly, I would like to wish all of you a Happy New Year!

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

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

From the President

Risk Minimisation vs Risk Avoidance: High Risk Surgery and the Courage to Fail

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

As SCTS steps into a new year, let me start with an issue at the core of our work as a profession. *This is the tension between risk minimisation and risk avoidance.* This is not a fancy discussion. It defines how we care for our sickest patients, how society interprets our work, and how we protect the integrity of our specialty.

In cardiothoracic surgery we routinely meet patients who are at high or imminent risk of death without intervention. Many carry major co-morbidities. Our work is unforgiving, and the stakes are high. There is the hope of survival and a return to good quality of life, but also the possibility of complications or dying.

Our surgeons and teams must perform at an elite level every day. That is why our training and standards are rigorous. That is why we must be resilient and have stamina. Technical excellence is only the beginning. High quality outcomes rely on *Teamship*, trust, communication, preparation, situational awareness, reflection and the insight to ask for help. Multidisciplinary thinking and dual consultant operating play an important part, alongside the ability to act decisively and independently when called upon. These qualities, together with institutional support and operative skill, are what make higher risk surgery both possible and safe.

Sadly, we have again seen periods of unhelpful media reporting which, knowingly or naïvely, amplify patient distress and undermine the work of dedicated cardiothoracic surgeons and their teams. Such pieces can be unbalanced and cannot be answered through a ding-dong of soundbites. What they cause is erosion of trust between patients, families and surgeons, and they provoke anxiety in our teams. This creates an atmosphere in which clinicians may become wary of taking on the very cases in which patients stand to gain the most.

This prompts a social question. What does society want us to do? Avoid difficult cases to avoid criticism, or be supported, encouraged and entrusted to take them on with care, skill and strong governance?

Patients and society benefit more when we pursue risk minimisation, not risk avoidance. In a media environment that can be supportive one day and hostile the next, we must also explain ourselves more clearly and loudly. Our place is not on the fence. We must speak up for our sickest patients. Patients and the public need to understand why some operations carry higher risk, how those risks compare with doing nothing, and how expert teams work to reduce them. Then can patients be properly informed when they give their consent. We do not take consent from patients; they give their consent to us!

There is a further point. Whenever we extend the boundaries of what is possible, we do so with less certainty than when performing an operation that has been carried out thousands of times before. These endeavours are not reckless. They are undertaken with careful consideration, multidisciplinary scrutiny and shared judgement. They demand integrity, prudence and courage. For that reason, society must support the teams who take on this work, not undermine them.

Back in 2015, we held a symposium on these issues and published an article *High Risk Surgery: the Courage to Fail* [1]. The themes discussed then remain just as relevant today.

2026

We look forward to our annual meeting in Belfast, where we will highlight progress in several areas, particularly our clinical transformation programmes. Our fundraising activities got off to a fantastic start with our first London to Brighton Cycle Ride. We plan for this to be a recurring event and invite you join us in September 2026. With your support, we hope to exceed our target and raise the visibility of the work cardiothoracic surgeons do to make heart, chest & lung surgery better.

We continue to strengthen SCTS by growing our Secretariat and launching our patient & public facing Friends of SCTS initiative, both of which we hope will progress significantly.

The joint meeting with ACTACC and the RSM was also a 'sold out' and overflowing success with much discussion about the vibrant future of our specialty, which is for us to make. We are planning our next event for later this year.

A Note of Thanks

My thanks to our editor and all contributors to this January edition. I have been impressed by the number, range and quality of submissions for this journal. The numerous fellowship and elective reports are especially uplifting. They showcase the curiosity, energy and ambition in our profession and reassure us that our future is in good hands.

Finally, thank you to all the senior leadership team and our active members. Wishing you a safe & successful 2026.

References

1. Pepper JR, Coonar AS. High-risk surgery: the courage to fail. Journal of the Royal Society of Medicine. 2015 Feb;108(2):44-6. **https://journals.sagepub.com/doi/full/10.1177/0141076815571515** ■

Honorary Secretary's Report

Doug West, Consultant Thoracic Surgeon, Bristol Royal Infirmary

This summer I was delighted to have the opportunity to become the Honorary Secretary. Two Executive, one BORS meeting and what feels like a thousand emails later, I can take stock of the first few months.

As the President has set out, we must grow as an organisation if we want to fulfil our goals and increase our impact. Our secretariat team, based at the Royal College of Surgeons, is vital to this mission. We are delighted to have welcomed new team members Nadia and Sophie to the team this summer, both after a very competitive interview process.

We also need to foster long-term relationships with an expanded membership and make sure that members feel real value from that membership. I remember the chilly morning in Aberdeen when I opened the letter from then-President Leslie Hamilton confirming my trainee membership. Membership has been a positive part of my career ever since and I want as many colleagues as possible to benefit from it too.

We moved some time ago from being an organisation only for surgeons to one that welcomes the whole team. Whether you are a surgeon, allied health professional or nurse, we are looking at ways we can make it easier to join the Society and to have a lifelong relationship with it. The society promotes our specialty through educational activities, connection to the cardiothoracic community through meetings and publications, representation and quality improvement initiatives such as the current cardiac MICS/ERACS programme.

With the proposed Friends of SCTS initiative, we are looking for ways that patients, families and the wider public who want to support our work and keep updated on SCTS activities could do so.

The Society is a great organisation to be part of. If you aren't a member already, please think about joining. ■

SCTS Honorary Treasurer

Mark Jones, Consultant Cardiothoracic Surgeon, Royal Victoria Hospital, Belfast

It is a great privilege personally and professionally to have served as Honorary Treasurer of the Society for Cardiothoracic Surgery in Great Britain and Ireland since March 2023. I have long held the work of the Society in high esteem, and just recently was reflecting on the enormous encouragement of receiving a letter from the Honorary Treasurer of the Society back in the year 2000, offering me a Scholarship to support my research at Duke University.

The Society has continued to support a broad range of educational activities through the work of the Senior Leadership Team and Executive. Sunil Bhudia has led a superb meetings team, and we look forward to the annual meeting returning to Belfast in March 2026. Karen Redmond has been appointed as the new Honorary Treasurer, and we plan to work closely to ensure a smooth handover. Debbie Harrington and Mike Shackloth have continued to oversee an extensive range of educational courses even in a time of financial constraints. The delivery of the educational materials through the on-line platform has been very well received. It has been particularly pleasing to see the continued collaboration of the Society with the Association for Cardiothoracic Anaesthesia and Critical Care, and the Cardiothoracic Section of the Royal Society of Medicine through the leadership of Aman Coonar, Enoch Akowuah and Doug West.

I have enjoyed working with Narain Moorjani and Rana Sayeed during my time on the Senior Leadership Team. Along with Hanad Ahmed, a trainee who worked in Belfast and East of England, Sri Rathinam, and Tim Jones, the former Chair of the Specialty Advisory Committee in Cardiothoracic Surgery, we are pleased to have published the SCTS-SAC Cardiothoracic Workforce Report 2025 (https://scts.org/_userfiles/pages/files/workforce_report_18032025_44.pdf).

The Society requires an income to function, and a proportion of this comes from the annual membership subscription and meeting registration fees. In addition, we have benefitted from generous donations in the past, enabling the Society to offer Educational Fellowships. We continue to review the legacy of such donations. Our President Aman Coonar has raised the profile of new fund-raising events, and we are building a wider team exploring how best to financially support the on-going work of SCTS. As an organisation, we value strong links with our partners in the healthcare industry. Many of these partners already support the annual meeting via exhibitor fees, as well as offering separate educational grants and fellowships.

There are significant costs related to the administration, management, and governance of SCTS. With an annual turnover of more than £1,000,000, we value the support and advice of our accountants and auditors in preparing the financial statements prior to annual submission to the Charity Commission. As Honorary Treasurer I have sought to bolster the SCTS contribution to improvements in the quality of healthcare delivered to patients in an open and accountable manner. In all this work, the constant support of our administrative team has been invaluable, and I welcome this opportunity to thank them for their hard work. ■

SCTS Meetings Report

Transformation in Cardiothoracic Surgery

Sunil Bhudia, SCTS Meeting Secretary, Consultant Cardiac Surgeon, University Hospitals Birmingham NHS Foundation Trust

Rosalie Magboo, SCTS Associate NAHP Lead, St Bartholomews Hospital, London

The preparation for our SCTS Annual Meeting 2026 is in full flow. After four years, our meeting will be in Belfast from 15th to 17th March 2026 and appreciate that this spans Mother's Day and St Patrick's Day. However, the team, including Rosalie Magboo, Carol Tan, Nisha Bhudia, Gianluca Lucchese, Emma Piotrowski, Tilly Mitchell, and Sunil Bhudia have been putting together an exciting programme. We continue exploring new ideas following from the success of the Edinburgh 2025 meeting.

The theme of the meeting will be transformation in cardiothoracic surgery as suggested by our President, Aman Coonar. There are three plenary sessions that will include a Presidential Plenary, a Transformation Plenary and an Ethical and Legal Plenary.

The Presidential Plenary on Monday 15th March 2026 will feature our President Aman Coonar (pictured right) and recognition of an individual with the Lifetime Achievement Award.

We are extremely excited to welcome Prof Emile A. Bacha (pictured below), the current President of the American Association for Thoracic Surgery (AATS). He is a world-renowned congenital heart surgeon and co-director of the Congenital Heart Centre at the New York-Presbyterian Hospital. He is a Professor of Surgery at Columbia University and Chief of the Division of Cardiac, Thoracic, and Vascular Surgery at New York-Presbyterian/ Columbia University Orving Medical Centre. He has pioneered procedures, guidelines, and technologies advancing congenital cardiac surgery.

His research interest is in improving safety and reducing invasiveness in paediatric cardiac surgery. His interest in innovation and transformation will add value to our meeting.

We are lining up experts from around the world and the United Kingdom to share and contribute in sessions across the three days.

The University Day on Sunday 15th March will have excellent educational sessions that will build on the success of previous meetings. The sessions will have traditional lectures and opinions from world renowned experts in thoracic surgery, cardiac surgery, congenital surgery, transplant surgery, and transformation.

In the Edinburgh meeting, wetlab sessions proved very popular with high levels of education. The spectrum of wetlab sessions will be increased to build on this popularity. We will utilise the expertise of various national and international faculty to enhance these sessions. The wetlab sessions will be complemented with dry lab sessions providing a hands-on learning experience to bridge theory and practice, helping attendees apply surgical or procedural skills and demonstrate the value of multidisciplinary teamwork in a very tangible way. Some sessions require registration so please register early to avoid disappointment.

Nurses and allied health professionals will have the opportunity to learn practical skills in conducting research and building a culture of evidence-based care. This event offers a rare opportunity for emerging professionals to learn directly from leaders in the field, while experienced clinicians gain fresh perspectives from the next generation of innovators and clinical experts. New for 2026 will be a designated thoracic session and an international session that will promote networking and collaboration amongst participants.

The SCTS INSINC Committee, the student group, will be welcoming medical students to give them a flavour of cardiothoracic surgery. Together with the entire cardiothoracic community we can inspire these medical students to a career in cardiothoracic surgery. The best abstract from the students will be awarded the Patrick G. Magee Student Prize.

The cardiothoracic trainees have an increasing contribution and will have a trainees' forum where they will get updates from educationalists. We will work with non-trainee doctors to increase their involvement and be part of the team.

The main meeting on Monday and Tuesday will be a combination of keynote lectures and abstract presentations to feature new knowledge, foster collaboration and inspire innovation. Beyond the technical and clinical sessions, the meeting will emphasize transformational leadership – empowering healthcare professionals to lead with empathy, adaptability and purpose. Finally, we invite you to take full advantage of the networking opportunities throughout the meeting to connect with peers, share insights and grow together.

There are various other prestigious prizes to be awarded. These include the Ronald Edwards Medal (best scientific oral presentation), John Parker Medal (best clinical presentation), Bob Bonser Aortic Surgery Prize, Society Thoracic Medal (best thoracic presentation), BASO Prize (best oncology presentation), Best Operative Movie Prize, Best NAHP Cardiothoracic Forum Presentation, and Best Poster.

We will be welcoming you all in Belfast to enjoy meeting and networking with experts, colleagues and friends not only at the annual meeting but also during the Annual Gala dinner, which will be in the evening of Monday 16th March at the iconic Titanic Museum – the very place where the Titanic was designed, built and launched. As in previous years, it will be a black-tie extravaganza.

We are, as always. thankful for the support from our exhibitors and continuing the collaboration for the benefit of patients.

This is a journey for all of us to transform cardiothoracic surgery for our patients and healthcare professionals. ■

SCTS EXECUTIVE COMMITTEE

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Perfusion Lead: Lisa Carson

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Research Lead:
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ACTSCP President – Nisha Nair

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Thoracic Surgery Rep:
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Raisa Bushra
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Deputy Chair:
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Appointed Members:
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Ruhina Alam
Jane Dickson
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Branko Mimic
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Appointed Members:
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Fathima Mubarak
Kudzayi Kutywayo
Bhuvaneswari Krishnamoorthy
Philip Hartley
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Trust Appointed Doctors in the UK: Progress, Challenges and Future Directions

Ghaith Qsous, Trust Appointed Doctors Lead, Clinical Fellow, University of Nottingham

Trust Appointed Doctors (TADs) now represent one of the largest groups within the cardiothoracic surgical workforce in the United Kingdom. According to the latest Society for Cardiothoracic Surgery (SCTS) Workforce Report, the number of TADs now mirrors that of consultants, with over 250 TADs currently working across the country. This reflects the importance of recognising, supporting, and empowering this group.

In recent years, the SCTS has taken important steps to strengthen the position of TADs. Three dedicated courses have been developed: the Cardiothoracic Curriculum Review Course, the Cardiothoracic Surgery Update and Wetlab Course, and the CESR/Portfolio Pathway Course. These initiatives provide tailored educational opportunities and equal access to most Society programmes alongside NTN trainees. TADs also have dedicated educational leads – Mr Mohammad Hawari (thoracic) and Mr Anas Boulemden (cardiac) – who continue to provide extraordinary support in education and career progression.

A landmark development came in the last year when the Society created the position of Trust Appointed Doctors Trustee – a formal representative role within the SCTS Executive Board. I am deeply honoured to have been elected as the first to hold this position, which I approach with great responsibility and commitment to representing the voices of my colleagues.

To better understand the current situation, I conducted two pilot surveys among TADs across the UK and Ireland. The findings were insightful but also deeply concerning.

I – Bullying, Harassment and Undermining (BHU)

Approximately 50% of respondents reported experiencing bullying, harassment or undermining behaviour. This aligns closely with the findings of Badran et al., who reported exposure rates of up to 65% within cardiothoracic surgery[1]. What makes this issue particularly alarming is the lack of a clear escalation pathway for TADs, leaving many feeling isolated and unsupported when faced with such incidents.

These findings were presented and discussed at recent SCTS Executive meetings, where I was encouraged by the strong commitment of SCTS leaders to address this issue. The Executive Committee also encouraged me to share with TADs the recent Royal College of Surgeons (RCS) policies outlining appropriate and safe procedures for reporting, managing, and resolving BHU incidents.

II – Recognition and Institutional Support

Another important initiative approved by the SCTS is the introduction of two annual awards:

- Best Trust Appointed Doctor of the Year, recognising excellence in clinical performance, academic engagement, and professional development.
- Best Department Supporting TADs, celebrating departments that demonstrate outstanding mentorship, training opportunities, and a culture free from bullying or harassment.

These awards mirror those already established for NTN trainees and will be launched at the upcoming SCTS Annual Meeting in Belfast (15th-17th March 2026). Their purpose is to celebrate the contributions of TADs and to motivate departments across the UK and Ireland to strengthen their support for this workforce.

III – Mentorship and the CESR/ Portfolio Pathway

One of the most striking findings from the surveys was the lack of formal mentorship. A majority of TADs reported not having an assigned Educational or Clinical Supervisor, and even among those who did, regular meetings were rare.

This lack of structured guidance is a critical barrier to professional progression, particularly for those pursuing the Certificate of Eligibility for Specialist Registration (CESR)/Portfolio pathway, which requires completion of 250 major cases over six years.

Most TADs reported performing fewer than four major cases per month – making it challenging to meet this requirement within the specified timeframe. This not only delays career progression but also contributes to feelings of frustration, stress, and professional stagnation.

IV – Burnout and Wellbeing

The psychological consequences of these challenges are significant. Up to 60% of respondents reported experiencing burnout – more than

double the 24.4% burnout rate recently reported among cardiothoracic trainees in the UK[2].

This finding should be viewed as a serious warning sign. While burnout among trainees has already been recognised as a major concern, the fact that TADs experience it at even higher rates underscores the urgent need for targeted support and wellbeing strategies.

Investing in the Future

Leadership and management skills are as vital as clinical and technical expertise. Many of our senior figures within the Society exemplify these attributes, and I am confident that they recognise the critical importance of supporting TADs in their professional journey.

TADs consistently demonstrate enthusiasm, dedication, and talent. Many current consultants and NTN trainees began their careers as TADs – clear evidence that, when given proper guidance and opportunity, TADs can progress to senior leadership positions within the specialty.

To quantify this impact, I conducted a short survey across 15 cardiothoracic units in the UK and Ireland (out of 49 in total). The results showed that 37 consultants appointed in the past five to seven years came from TAD backgrounds – with some units having as many as five such consultants.

This finding reinforces that TADs are not only a vital part of our present workforce but also key architects of the future of cardiothoracic surgery. We train future trainees, deliver frontline patient care, and contribute significantly to research and innovation.

Therefore, investing in the training, mentorship, and wellbeing of TADs is not merely an act of fairness – it is an investment in the quality and sustainability of our specialty.

Looking Ahead

Meaningful change will require collective effort. Together, we can ensure that Trust Appointed Doctors receive the respect, recognition, and opportunity they deserve.

As the elected Trust Appointed Doctors Trustee, I take this role with deep responsibility. I am committed to speaking honestly and courageously on behalf of my colleagues and to working collaboratively with the SCTS leadership to build a future defined by equality, support, and opportunity for all. ■

Ghaith.qsous@nhs.net

References

1. Badran A. *Bullying and Harassment in Cardiothoracic Surgery: A Persistent Challenge. SCTS Bulletin.*
2. Jones T. *Burnout Among Cardiothoracic Surgery Trainees in the UK: An Emerging Concern. SCTS Bulletin.*

SCTS Nurses and Allied Health Professional Update

Amanda Walthew, NAHP Representative, Lead Surgical Advanced Nurse Practitioner, Liverpool Heart and Chest Hospital

Nurses and allied health professionals are at the forefront in improving healthcare delivery of care. The NHS long term plan aims to improve health outcomes and provide a better quality of care for all. NAHP's play a pivotal role within the SCTS in the delivery and ambitions.

I have worked within cardiothoracic surgery for almost thirty years and have seen a dramatic change in patient management. From open surgery and long stays in hospital, to now minimally invasive surgery and enhanced pathways of care, ensuring patients receive the best possible treatments available. This has led to extended roles for NAHP's, increased responsibilities and a broader scope of professional practice. The priority at present for our members is to enable you all to collaborate with us, network, communicate and share your best practice so we can all learn from each other to ensure patients are receiving the best care. You can help by sharing your service improvements and research-based practices with us. This can be via our annual meeting or even a story which could be highlighted in the next bulletin.

Advanced nurses and allied health professionals audit day at Liverpool Heart and Chest Hospital.

In June 2025 we arranged a day for staff to showcase their work in service development, research and best practice, seventeen abstracts were accepted and presented on the day. My SCTS experience was vital in the organisation. This gave an opportunity for staff to engage with other teams in the Trust, learn from each other and network. The day was a great success and supported by our industry partners, it included a wet lab, demonstrations and education. Thank you to Ethicon, Medela, AtriCure, Medtronic, Terumo and Rocket medical.

If you would like advice on how to arrange an event for your staff then please contact me. **Amanda.walthew@lhch.nhs.uk**

Education

Education Lead – Kathryn Hewitt

The National training webinars have been a remarkable success from feedback received by the NAHP team. Please share with your NAHP teams that webinars which run weekly are accessible for live and retrospective viewing and to emailplease amanda.walthew@lhch.nhs.uk for more information. They will generate a certificate for staff if attended and can be viewed retrospectively if the live sessions cannot be attended.

A face-to-face NAHP cardiothoracic course at the Getinge facility took place this month over two days. It included separate cardiac and thoracic day sessions, presentations and interactive sessions.

SCP Update

SCP SCTS lead and ACTSCP President – Nisha Nair

The Association of Cardio-Thoracic Surgical Care Practitioners (ACTSCP) successfully held its 4th Annual Cardiothoracic Workshop on 1st November 2025 in London. The event brought together Surgical Care Practitioners (SCPs) and multidisciplinary professionals from across the UK for a day of education, collaboration, and practical learning within the field of cardiothoracic surgery. The workshop featured an excellent blend of interactive lectures, case discussions, and direct training sessions, designed to enhance both technical skills and clinical understanding. Delegates had the opportunity to engage directly with experts, explore innovative technologies, and share best practices ... fostering a spirit of teamwork and continuous professional development.

The ACTSCP Executive Team extends its sincere gratitude to all those who contributed to the success of the day ... from speakers and facilitators to representatives and participants. Your dedication, enthusiasm, and professionalism were instrumental in creating such a dynamic and engaging learning environment.

A special thank you goes to Meril for their incredible contribution and for being the sole sponsor of this year's event. Their ongoing support and collaboration were key to ensuring the smooth running of the programme and enhancing the learning experience for all attendees.

"I feel truly privileged and proud to lead such a passionate and dedicated community. The success of this workshop is a testament to the collective effort, commitment, and collaboration of everyone involved."

The 4th Annual ACTSCP Cardiothoracic Workshop not only celebrated teamwork and excellence but also reinforced the growing role of Surgical Care Practitioners in advancing patient care and innovation within cardiothoracic surgery. ACTSCP looks forward to building on this success and continuing to provide high-quality educational opportunities and professional support to SCPs across the UK in the years ahead.

Research Update and Annual Meeting

The National Research Meeting, Friday 7th November 2025, went ahead with Professor Judith Tanner as keynote speaker. This is a yearly event so look out for the next one and highlight your work.

The research NAHP webinar in June was a great success.

The Associate PI Scheme has a number of RCTs being run in cardiac surgery. For more information contact **rosalie.renamagboo@nhs.net**.

Perfusion

Perfusion Lead – Lisa Carson

There will be a National Rollout of Minimally Invasive Cardiac Surgery (MICS) ERACS. Therefore, perfusion teams will need to be trained. Concerns have been expressed as most cannulas used for these procedures are supplied by one company. They are manufactured in the United States of America and supply of these can sometimes be an issue so could be problematic going forward. Finally, we are awaiting the outcome from NHS England on the commissioned use of 'post cardiotomy ECMO'.

Key Priorities for 2026

– Team succession planning and recruitment
– Research
– Website development for NAHPs
– Increasing NAHP membership/collaboration
– Education

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**. We have a national WhatsApp group for members to join. This is used for collaboration, advertising events and general updates.

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

New Thoracic NAHP Lead Appointment

Stacey Stockdale – **Thoracic advanced practitioner South Tees Hospital**

Stacey qualified as a nurse in 2000 and has experience in respiratory medicine, Lung Clinical Specialist nursing, Community Palliative Care and now thoracic advanced practice. She has been instrumental in establishing a Community Thoracic Service, enhancing patient care across hospital and community settings. She actively encourages developments of all NAHPs within thoracic surgery, working closely with Physiotherapy and Pharmacy colleagues to enhance patients care and experience. ■

SAC Chair Report

Mark Jones, SAC Chair, Consultant Cardiothoracic Surgeon, Royal Victoria Hospital, Belfast

Stepping into my new role as Chair of the Specialty Advisory Committee in Cardiothoracic Surgery I am immensely grateful to out-going Chair Tim Jones for his inspiring work and leadership.

In terms of recruitment and selection, our National Selection Board continues to promote successful 'run through' training with entry at ST1, aiming to ensure that we appoint the appropriate number of people on an annual basis to our training programmes. We were delighted to publish the SCTS-SAC Cardiothoracic Workforce Report 2025 which will help inform such work (**https://scts.org/_userfiles/pages/files/workforce_report_18032025_44.pdf**). We are grateful to everyone who contributed to the report.

Our Quality Assessment team have been reviewing data from all regions and highlighting excellent practice as well as areas for improvement. In the incoming year we would encourage all trainees and trainers to contribute fully to the GMC and Joint Committee on Surgical Training Quality Surveys.

The Cardiothoracic Surgery Curriculum is currently being updated. We want to ensure that it is relevant to current practice while at the same time increasing the range of index and major cases. Proposals to achieve this have been submitted to the GMC for review, with the new curriculum launch anticipated in August 2026.

My vision as Chair of the SAC in Cardiothoracic Surgery is to build upon my six years of service on the committee, working hard with colleagues across the full range of SAC roles to develop the next generation of surgeons and future leaders in our specialty, addressing educational challenges collaboratively. As a member of the Senior Leadership Team and Executive Committee of SCTS I look forward to consolidating and developing the excellent working relationships already established with SCTS, working with Aman Coonar and Enoch Akowuah to this end.

I would like to take this opportunity to thank all SAC members and express particular gratitude to Mohamed Sherif and Ali Ansaripour, our Trainee Representatives. The contribution of all members is voluntary, highly valued, and vital for successful training and optimum patient care. Further information about membership of the SAC can be found at the JCST **https://www.jcst.org/**. ■

Audit Committee Update

Uday Trivedi, SCTS Audit Lead,
Consultant Cardiac Surgeon, University Hospitals Sussex NHS Foundation Trust

Thoracic Surgery

There has been significant progress with the development of a new Thoracic surgery database. A number of working groups have delivered disease specific datasets. Further work has also been undertaken to ensure that the data from the units will meet the GDPR requirements. If progress continues at this pace, it is envisaged that a demonstration will be available at the SCTS annual meeting in Belfast. Further details can be found elsewhere in this issue of The Bulletin.

Adult Cardiac Surgery

First, I want to thank Andrew Goodwin for his dedication to the National Adult Cardiac Surgery Audit with NICOR. Thanks to his efforts and the NICOR team's work, they've improved audit and data collection so much that reports are now finished within the same year – a notable achievement considering NICOR's work on other audits. I'm pleased to take on this role and am eager to continue advancing the audit.

Taking on this role along with being the SCTS audit lead goes back to the early days of adult cardiac surgery. The aim is to restore a better relationship between the SCTS and NICOR. Moving forwards the aim would be for the SCTS and other professional bodies to direct the direction of the audit. This September there was a meeting between NICOR, SCTS, BISMICS and UKAS, along with patient participation, to discuss this very matter.

The role of NICOR is primarily to drive quality improvement and undertake the annual analysis of unit and surgeon specific outcomes. The SCTS and its members have further requirements related to audit and research. Currently the SCTS does have access to anonymised data as part of the SCTS Dashboard. To date we have data on over 25,000 patients and 20 units have signed the Data Sharing Agreement. Access to this data for audit and research projects is being discussed (as this was one of the aims of the dashboard) with the obvious limitations of an anonymised dataset.

Whilst 25,000 patients is a good number, the ask from the SCTS if for all units to sign the DSA and upload as much data as they have. The bigger the data base the more useful it will be for researchers. Units do not have to use any particular software as it is possible to extract the data from any system. Anyone who is having difficulty with either internal clinical governance matters or technical issues with data uploads should contact me directly.

The Quality Assurance Programme continues to be the backbone of the national governance process. It is vital that the SCTS gets a response to the QAP form from each unit every quarter so that stakeholders can be reassured that our self-policing is an active on-going process. The importance of this was made evident this year when the outcomes analysis identified one unit to be an alert, and it was reassuring that the unit had filled in the QAP form every quarter and were aware of their outcomes. Had this not been the case, it would have been a different and very difficult conversation with the unit's medical director.

"To date we have data on over 25,000 patients and 20 units have signed the Data Sharing Agreement. Access to this data for audit and research projects is being discussed."

Congenital Surgery

Work continues on the Blue Book. It remains in the writing phase with all the data analysis having taken place.

An agreement has been reached between NICOR and SCTS to have a congenital surgeon as part of the clinical leadership of the congenital audit. ■

SCTS Annual Meeting 2026

15th-17th March

National and International Speakers

Christoph Nienaber, Dennis Manzanades, Emile Bacha, Enrico Ruffini, Ferdi Acka, Gianluca Torregrossa, Jean Colombel, Julie Cleuziou, Kamran Abbasi, Laurens Ceulemans, Madalina Garbi, Manuel Carnero, Manuel Castella, Martin Czerny, Melissa Rochon, Morad Sallam, Muhammad Mohiuddin, Pierre-Emmanuel Falcoz, Rebecca Duerden, Rob Smith, Said Abisi, Santiago Figueroa, Spyridon Gennatas, Tiffany Patterson, Tom Newsom-Davis

Main Meeting Programme

- Presidential Plenary
- Scientific Abstracts and Keynote lectures
- Industry Exhibition & Symposiums
- Late breaking trial launch announcements
- Lifetime Achievement Award

SCTS University

- Will cover Xenotransplantation to robot assisted cardiac surgery to “How I do It”
- Challenges in the management of early stage as well as locally advanced NSCLC
- Surgery on the Thymus gland and Chest wall conditions
- Building a culture of evidence-based care
- Crafting better researchers: Skills for Scholarly Success
- Inside the chest: Innovations reshaping thoracic surgery
- Clear the Way: Airway strategies and the MDT approaches after cardiothoracic surgery

CT Nurse & Allied Health Professional Forum

- Elevating expertise: mastering advanced clinical skills for exceptional patient care
- Better care, better outcomes: Innovation and QI in Cardiothoracic Surgery
- Bridging protocol and pathways: QI-driven pathways in cardiothoracic surgery
- Digital technology: the good, the bad and the ugly
- Empowering excellence: Innovative approaches to healthcare education and support

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Social Events

Sunday 15th March
Welcome Reception in Exhibition Hall

Monday 16th March
SCTS Annual Dinner at the Titanic Belfast

Up to 18 CPD points

Registration is now open

Early bird discounted rates until 31st January 2026
To register or view the detailed programme please visit www.scts.org

ICC Belfast
15–17 March
scts.org

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SCTS Education Secretaries Report

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

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

Nathan Burnside, Thoracic Surgical Tutor,
Consultant Thoracic Surgeon, Nottingham City Hospital

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

SCTS education continues to provide a comprehensive portfolio of courses aligned to the curriculum for all our trainees, allied health care professionals and medical students. 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.

Education Committee Appointments

There have been several appointments to the education team. Mike Shackcloth was appointed Education Secretary following the appointment of Elizabeth Belcher as Intercollegiate Exam Board Chair. Nathan Burnside has been appointed as Thoracic Tutor and Pasan Witharana has been appointed SCTS Education Website Development Lead. Thanks to all our subcommittee members, course directors, and faculty in all our education streams, who continue to provide excellent training opportunities in an increasingly challenging financial environment.

SCTS Fellowships and Collaborations

The Heart Research UK Travelling Fellowships for 2025, totalling £40,000, have been awarded to Ghazi Elshafie (Thessaloniki, Greece), Marcus Taylor (Alfred Health, Australia), Nabil Hussein (SickKids, Toronto), and Yousef Salmasi (Universitaires St-Luc, Brussels). The final round of three ACT-Michael Warburg SCTS Fellowships, agreed at £20,000 per annum, have recently been advertised.

Andrew Brazier and Amer Harky have commenced in post as Liverpool Aortic Post-CCT Fellows, both accredited jointly by SCTS and RCS Edinburgh. SCTS Post-CCT Fellowships provide high-quality, high-prestige, and quality-assured advanced training in Robotic Thoracic Surgery, Complex Aortic Surgery and Complex Mitral Surgery.

NTN Education

We would like to express our thanks to Meril who generously supported the delayed ST5.1 course which took place at Medizin im Grunen near Berlin in October. The course was a great success, and we are grateful to all our faculty, including the perfusion team, for taking part.

Many thanks to Kasra Shaikhrezai and Aiman Alzetani who successfully ran a new ST2 course in Nottingham this year, combining the previous two courses. The ST4.1 Core cardiac surgery course ran at Ashorne Hill, using a combination of talks and wetlabs to provide trainees with the skills needed in Phase 2 of their training.

At the other end of training, the S7.2 Leadership and Professional development course at the end of November helped prepare trainees for the beginning of their consultant career. The first day utilised insights to help trainees better understand themselves as individuals and leaders and how to utilise this to communicate and influence people; vital skills needed by consultants. The second day covered skills necessary for consultant interviews and areas that aren't covered in the curriculum but are essential knowledge for the early years of a consultant career, e.g. job plans and introducing a new procedure.

We were delighted to welcome the new ST1 cohort to Ashorne Hill in December for their first course. This course gives an overview of the specialty, including tips and tricks for successful training as well as a chance to meet their contempories.

Trust Appointed Doctor Education

Anas Boulemden and Mohammad Hawari continue to lead the TAD Portfolio. The Portfolio Route (formerly CESR) Course and Curriculum review course were both very popular and received excellent feedback.

National Online Cardiothoracic Training Programme

The National Online Cardiothoracic Surgery Education platform is ongoing, delivered by Mike Shackcloth and Georgia Layton. It is open to NTNs, TADs, and NAHPs. Live webinars are at 8am every Thursday morning, and there are videos of over 50 talks on the PGVLE platform. You can sign up for a log in to the platform at **https://docs.google.com/forms/d/e/1FAIpQLSc4hSDFiYhsiEi5UuMdgQw6rxXsfVDJSbX1R4RXRSc2JXRKfQ/viewform?pli=1**

Medical Student Education

Thanks to Jason Ali and Shilajit Ghosh, our SCTS Student Education leads. A new committee has been appointed, and a successful engagement day took place at Royal Stoke University in November.

NAHP Education

Led by Kathryn Hewitt, the NAHP portfolio continues to grow. A face-to-face cardiac and thoracic course is planned for January 2026 at the Gettinge Facility in Derby.

Industry Partnerships

We are extremely grateful to J&J MedTech for their ongoing support of SCTS Education. They have funded multiple courses including the ST3.1, ST4.2, ST7.2, TAD wetlab, and the TAD Curriculum review course. They have also contributed to the ST7.1, ST1 and ST2 courses. Meril have funded the ST5.1 course in Berlin. We are also grateful for the support of Edwards, Atricure, Artivion, Acumed, and Pulmonx, without whose support we would not be able to run our courses.

Finally, special thanks to Mara Banuta, our SCTS Education Administrator, for her invaluable support, dedication and commitment to ensuring courses run smoothly and efficiently despite the numerous challenges involved. Please ensure that your contact details are up to date and that when you are invited to a course, you respond as quickly as possible.

We look forward to seeing many of you at our courses in 2026, further details to follow on the website soon. ■

SCTS Education Course Calendar 2026

Course	Location	Date
ST3.2 Phase 1: Non-operative technical skills for surgeons (NOTSS)	Bristol Simulation Centre	26th–27th February 2026
Phase 3: Revision & Viva Course for FRCS CTh	Online and Ashorne Hill	14th–17th April 2026
ST5.2 Phase 2: Cardiothoracic Intensive Care and Critical Conditions Course	Ashorne Hill	27th–28th April 2026
ST3.1 Phase 1: Operative Cardiothoracic Surgery Course	Medizin im Grunen	7th–8th May 2026 TBC
SCTS Harefield Core Thoracic Organ Transplantation Course	STaR Centre, Harefield	TBC May 2026
ST5.1 Phase 2: Cardiothoracic Surgery Sub-speciality Course	TBC Medizin im Grunen	18th–19th June 2026 TBC
TAD Cardiothoracic Surgery Update & Wetlab	J&J Medtech Pinewood	June 2026 TBC
ST7.1 Phase 3: Cardiothoracic Pre-consultant Course	Keele Anatomy & Surgical Training Centre	June/July 2026 TBC
ST2 Phase 1: Essential Cardiothoracic Surgery Course	Nottingham City Hospital	21st–22nd September 2026
Curriculum Review Course for TADS	J&J Medtech Pinewood	September 2026 TBC
Portfolio Route Course for TADs	Ashorne Hill	6th November 2026
ST4 Core Cardiac and Thoracic Course	TBC	November TBC
ST7.2 Leadership and Professionalism Course	Ashorne Hill	26th–27th November 2026
ST1 Introduction to Cardiothoracic Surgery Course	Ashorne Hill	4th December 2026

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

Engagement with NICE

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

- **Ongoing: Interventional Procedure:** IP1071/2: New Guidance in development: Following initial consultation on the subject of Veno-Arterial Extra Corporeal Membrane Oxygenation (VA ECMO) for Post Cardiotomy Cardiogenic Shock (PCCS), NICE proposed the following recommendations;
  - 1.1: More research is needed on VA ECMO to manage PCCS before it can be used in the NHS.
  - 1.2: This procedure should only be done as part of formal research and an NHS research ethics committee needs to have approved its use.

  Following extensive rebuttal and discussions, the recommendations are now revised to;
  - VA ECMO can be used in the NHS during the evidence generation period as an option to manage PCCS in adults. There must be enhanced informed consent and auditing of outcomes.
- **Ongoing: Interventional Procedure:** IP2042: 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 & Endorsements on Proposed Guidelines

ACSSC has been tasked with deliberating and creating a position statement for SCTS by the Executive. 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 include;

- SCTS position statement regarding provision of Post Cardiotomy ECMO support at Non transplant Cardiac Surgical units in the United Kingdom. Mr Hari Doshi and Professor George Krasopoulos drafted the statement, submitted to the Executive and published on the SCTS website on 2nd June 2025.
- National guidelines for glycaemic control for patients undergoing Cardiac Surgery: Proposed National guidelines created by Mr Manoraj Navaratnarajah, Mr Kamra Baig, Professor George Krasopoulos and Professor Sunil Ohri. Awaiting further input from Endocrine, Anaesthetic colleagues and formal endorsement sought from relevant associations, such as the Association of British Clinical Diabetologists, ACTACC, the Centre for Peri-operative Care at the RCoA, and patient groups.
- National Guidelines for Adult Mitral valve disease. Comprehensive and excellent work undertaken by Mr Hunaid A Vohra, Mr Samuel Burton, Miss Rashmi Yadav, Mr Manoj Kuduvalli, Mr Rana Sayeed, Mr Narain Moorjani. ACSSC has reviewed the guidelines and submitted to the Executive. Published on the SCTS website on 10th March 2025.
- GIRFT Pathway for patients with AS: ACSSC was invited to discuss and comment on the Cardiology GIRFT AS pathway. Following discussions, recommendations were submitted in January 2025.
- SCTS endorsement for the BHVS statement: The British Heart Valve society (BHVS) Council 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 were submitted to the SCTS Executive committee in January 2025.

SCTS Position Statements & Endorsements on Proposed Guidelines

- 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.
- ACSSC was involved in preparation of a response to factually incorrect news regarding a surgical procedure.
- Review of JD for upcoming Substantive consultant's posts at various trusts.

Update on Other Projects

- Guidance document on sAVR / TAVI to support the membership of a 'Surgeon' in MDM discussions: Draft being prepared by Mr Reuben Jeganathan and Mr Giovanni Mariscalco.
- Aprotinin statement: Nordic aprotinin patient registry (NAPaR) outcomes; concerns regarding very high level of off-label use of Aprotinin in the UK. Following discussion at the Cardiovascular expert advisory group & Commission on Human Medicines, MHRA is looking for a response from the SCTS regarding this.
- NHS England is developing a CVD Modern service framework as part of a 10 year plan of "Fit for the future: 10 year Health Plan for England": Initiatives to reduce premature deaths in young patients by 25% in 10 years time: Ongoing work. ■

Thoracic Surgery Sub-Committee Report

Karen Redmond, SCTS Thoracic Surgery Sub-Committee Co-Chair, Consultant Thoracic Surgeon, The Mater Hospital, Dublin

Rory Beattie, SCTS Thoracic Surgery Sub-Committee Co-Chair, Consultant Thoracic Surgeon, Royal Victoria Hospital, Belfast

2025 has been a year of steady progress and renewed momentum across thoracic surgery and pectus care. Under the guidance of the SCTS Thoracic Surgery and Pectus Subcommittees, teams across the UK and Ireland have worked together to shape workforce strategy, expand data capability, and strengthen multidisciplinary collaboration. I would like to thank everyone involved for their exceptional and dedicated input, especially my outgoing co-chair Mr Rana Sayeed, Deputy Co-chair Mr Rory Beattie and new Executive Co-chair Doug West.

Building the Workforce for the Future

The joint **SCTS–SAC Workforce Report (2025)** projects an increase in consultant numbers from **120 to 175 whole-time equivalents**, reflecting the demands of national lung cancer screening and the evolution of thoracic practice.

Subcommittee discussions throughout the year have focused on defining a **standardised model job plan**, fairer rota design, mentorship for early consultants, and legal clarity around weekend operating and SPA allocations. The goal is a consistent framework that supports both patient care and surgeon wellbeing.

Data Takes Centre Stage

A major milestone for 2025 has been the signing of the **Dendrite Clinical Systems** contract in July, marking the next phase of the national thoracic registry.

The registry will capture key outcomes, including **survival, complications,** and **ePROMs**, giving units real-time insight into performance and supporting quality improvement. A dedicated **data manager post** and training workshops are being developed to support implementation.

The first full launch of the registry is planned for the **SCTS Annual Meeting 2026 in Belfast**, a landmark step in strengthening thoracic data governance and transparency.

Research and National Guidelines

Research collaboration continues to expand through the **James Lind Alliance (JLA) Priority Setting Partnership**, which has received over **700 responses**, more than half from patients. The partnership will define the **Top 10 Thoracic Research Priorities** to be presented in 2026, ensuring patient and clinician voices shape future studies.

Meanwhile, the **Empyema and Trauma** Working Groups are finalising national guidelines, and new groups covering **Airway**, **Diaphragm**, and **Lung Volume Reduction** are developing regional care standards. A proposal for a national **Thymoma MDT** is also underway.

Innovation and Partnership

Technological collaboration remains high on the agenda. The subcommittee continues to engage with the **NICE robotic surgery review**, with five robotic platforms currently under evaluation.

At the same time, the **VERITAS Project (Very Enhanced Recovery in Thoracic Anaesthesia and Surgery)** aims to improve perioperative recovery, while the SCTS Executive continues to expand patient engagement through the Friends of SCTS programme and digital branding initiatives, including QR-linked fundraising and a redesigned website.

Addressing Under-Recognised Conditions

Progress is being made on the **Thoracic Endometriosis Pathway**, a collaboration between SCTS and NHS England to raise awareness and define referral routes for a condition that has often been overlooked in surgical planning. The subcommittee will help ensure thoracic expertise is embedded in multidisciplinary guidance.

Pectus Surgery: Expanding Standards and Support

The **Pectus Working Group** has seen a particularly active year.

The landmark **RESTORE Trial** completed recruitment ahead of schedule, with data now under analysis. The trial has already influenced practice, with **CPET and CT at one year** becoming standard follow-up in the St Barts national MDT.

In parallel, the group has advanced the **Delphi Consensus for Non-Surgical Care**, including bracing, vacuum bell therapy, and physiotherapy. The forthcoming **Pectus Care Standards**, jointly endorsed by **SCTS, BAPS, and EACTS**, are expected to be published in 2026.

Access to non-surgical care remains a key focus. Following Scotland's recommendation for vacuum bell therapy, the group is preparing a **UK-wide position statement** to support equitable commissioning across the devolved nations.

Education has also expanded, with physiotherapy webinars held in September and a psychological support network forming across centres in Scotland, Middlesbrough, and Dublin. A **Pectus Surgical Skills Workshop** and **fellowship observerships** are planned for 2026.

Charity and Patient Engagement

The *Pectus Matters* charity continues to grow, driving awareness, research engagement, and peer support. A new postoperative survey has received strong participation, while a **medical alert bracelet initiative** is due to launch later this year.

Plans are underway to integrate *Pectus Matters* more closely with the SCTS website and to develop a dedicated "Chest Wall School" education platform similar to Scotland.

Looking Ahead

As 2025 draws to a close, both subcommittees are looking toward a year of delivery and publication. Key goals for **2026** include:

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- Launch of the **National Thoracic Registry** in Belfast.
- Publication of the **Top 10 Thoracic Research Priorities**.
- Finalisation of **Non-Surgical Pectus Care Standards**.
- New **Thoracic Trauma** guidelines.
- Pilot of **National MDTS including a Thymoma MDT**.
- Expansion of the **VERITAS Recovery Project** across UK units.

"This year has been about building the foundations for a more connected, data-driven and inclusive specialty," said Professor Karen Redmond. "The work achieved across both the Thoracic and Pectus committees shows what collaboration can deliver when the focus is on patients and progress." ■

Communications Committee Report

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

The last six months have seen changes and evolution within the SCTS senior leadership team with communications strategies supporting the new vision.

SCTS has had an invigorated presence in social media, with technology able to channel posts to the website in our media wall, and with the communication team supporting the President and the senior leadership team in progressing their vision and mission.

Communications Secretary as Trustee

By the time this edition reaches you we will have a new communication secretary who will also be an appointed trustee as I hand over the reins. This truly will be my last report as Communication Secretary. I am grateful to all the committee members and the Executive in supporting the various ventures we proposed and delivered. I am sure my successor will take things to greater heights.

We thank Emma, Tilly, and Mara for their hard work in delivering our various projects. We welcome Nadia and Sophie, as well as Isabelle who has returned briefly to support the team with *the bulletin*.

Bulletin

This issue had a phenomenal number of articles which the editorial committee under the stewardship of our editor Dio Stavroulias, had a great challenge screening and choosing. It was gratifying to see so many fellowship articles from Ionescu Fellowship winners which were awarded in my previous role as Education Secretary.

Newsletter

The communication committee has responded to requests by members to have streamlining in the form of weekly newsletters. We request members spend a few moments scanning the contents which will help us reduce the number of communications. The newsletters are also archived on our website should members want to revisit them.

From the Chest

For the collective creativity we have in our specialty, I am surprised that we haven't been flooded with articles. Thank you to all the contributors making it an interesting read as well as revealing the various aspects of our members lives. Keep them coming.

Social Media

Our social media posts and views have significantly increased. The huge promotion of the London to Brighton Cycle Ride by the SCTS team, our partner charities and riders opened new viewership and followership.

The meetings secretary and his team have created videos for the annual meeting which has resulted in the maximum number of abstracts. Please tag, share and repost SCTS posts to increase our social media presence.

Communication ambassadors

We have identified keen volunteers within the committee to screen and source relevant key topics and publications as social media streams for our members. Please look out for this scientific bonanza in the forthcoming months.

Friends of the SCTS

The SLT is finalising the terms of reference for 'the Friends of SCTS' and once it is finalised the Website will have details. We encourage members to raise awareness and share it with patients and public both to raise awareness and to help raise funds for the charity.

Secondary names and Taglines

We are proud as a society which has evolved from being a Society of Cardiothoracic Surgeons to a Society for Cardiothoracic Surgery. But the general public still do not identify with a scientific name. We have been debating about a secondary name to reach the public with suitable tag lines. SCTS will also have ***'Society for Heart, Lung and Chest Surgery'*** with taglines ***#Making Heart and Lung Surgery Better*** and ***#Looking after you every beat and breath you take***. Please feel free to add these to your social posts and tag SCTS.

Feedback

Please reach out and feedback and help us get better. We will only get better if we are critiqued, guided and supported to serve the Society.

Thank you

As I sign off, a big thank you to all of you who helped me in this role to develop a communication strategy and help support Presidents and the Executive in that journey. There are many more miles ahead as Albert Einstein said, 'Learn from yesterday, live for today, hope for tomorrow'. Let's hope for a bigger and better tomorrow for our Society with the Communication team supporting the journey. ■

Congenital Sub-Committee Report

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

Unlike the other subcommittees, because the congenital surgical fraternity is so small, the sub-committee is comprised of a representative from each unit. Not only does this allow clear and rapid dissemination of information and concerns throughout the speciality, but also that we are able to speak with 'one voice'.

More than other subspecialities within cardiothoracic surgery, we have been faced with severe challenges in retention of workforce over the last decade with 52% of the senior workforce leaving the speciality for various reasons; of those leaving 30% had retired but 56% had left the UK. There is a large cohort of surgeons in training and medical students deeply committed to the speciality and it is imperative that we create a working environment that allows them to reach their full potential.

The chief driver for surgeons deciding to leave the country has been frustration at the availability of resources to allow them to provide the service they believe their patients require. The SCTS is supporting the surgeons in drawing up a document of 'What a good centre looks like' hoping to elicit support from the fund holders in this effort. The document will be circulated to congenital colleagues within the next few weeks.

Other work the sub-committee is involved in is exploring whether there can be a congenital element included in the intercollegiate speciality examination for candidates who specifically express a commitment to congenital cardiac surgery. Currently, the oral section of the final accrediting exam does not test a candidate's knowledge in congenital surgery. This is an anomaly as there is a full syllabus for the sub-speciality but more than this surgeons may be exposed to criticism as their expertise in the field is never examined. Discussion is in the early stages.

Finally, the national congenital database (NICOR) is different to other streams in as much as both cardiological and surgical procedures are included within the same domain. To date the congenital domain has been led by a cardiologist with the risk that surgical input could be more limited. With SCTS support we have had discussions resulting in agreement that there will be a chairperson and vice-chairperson; one from each discipline so that both are equally represented on the board. ■

Intercollegiate Speciality Board in Cardiothoracic Surgery

Elizabeth Belcher, Chair, Intercollegiate Specialty Board in Cardiothoracic Surgery, JCIE, Consultant Thoracic Surgeon, John Radcliffe Hospital, Oxford

ISB Specialty Board in Cardiothoracic Surgery

Miss Elizabeth Belcher	Chair
Professor Farah Bhatti	RCSEng
Mr Neil Cartwright	Leader, Panel of Question Writers [S1]
Mr Mark Jones	SAC Chair
Miss Juliet King	Leader, Panel of Question Writers [S2]
Mr Manoj Kuduvalli	RCPSGlas
Mr Andrew Parry	SCTS
Mr Steven Rooney	RCSEd
Mr Rana Sayeed	JSCFE Lead
Mr Vincent Young	RCSI
Mr Alexander Smith	Trainee Representative
Mrs Elaine McDaid	Specialty Manager

As the new Board Chair, I would like to thank the outgoing Chair, Sri Rathinam, for his contributions to the development of the Cardiothoracic Specialty Examination. During his term, he oversaw a change in the examination format, aligned with the 2021 curriculum, and implemented larger examinations in response to the development of a Section 2 waiting list. Thank you also to our outgoing Board members, Neil Roberts, Narain Moorjani and Rebecca Weedle.

London Examination

Thanks to Sunil Bhudia, our host examiner for the London diet in October 2025 and to Sofina Begum who assisted with the

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thoracic component. We are grateful to Elaine McDaid, our specialty manager, and Archie Grey, our administrator. Thanks to the hard work of our hosts and secretariat, we were able to hold our second successive 32-candidate diet.

Sample Questions

The JCIE will shortly upload 50 Section 1 sample questions to their website. These sample questions align with the feedback domains.

Future Examinations

The next Section 2 examination will be held in May in Crewe, and we are grateful to our host examiner, Mr Shilajit Ghosh and to Mr Lognathen Balacumaraswami of the Royal Stoke University Hospital. The next Section 1 examination will be held on the 9th July 2026.

McCormack Medal

The McCormack Medal is awarded annually to the highest-scoring first attempt candidate. Congratulations to Mr Manraj Singh Sandhu, the winner of the McCormack Medal 2025.

JSCFE

The JSCFE examination will end with the final Section 2 examination in Edinburgh in November. There will be one further Section 1 examination in July for candidates already in the system. Candidates who do not complete Section 2 of the JSCFE examination may be eligible to receive a Certificate in Cardiothoracic Surgical Sciences in recognition of their achievement in Section 1.

Examiner Applications

The Panel of Examiners represent all four nations, but not all training regions and Trusts. We continue with examiner recruitment and welcome applications to the Panel of Question Writers and to the Section 2 Panel of Examiners.

Criteria for appointment and the process of application can be found in the links below:
www.jcie.org.uk/content/content.aspx?ID=41
www.jcie.org.uk/content/content.aspx?ID=23 ■

Demitted Roles

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

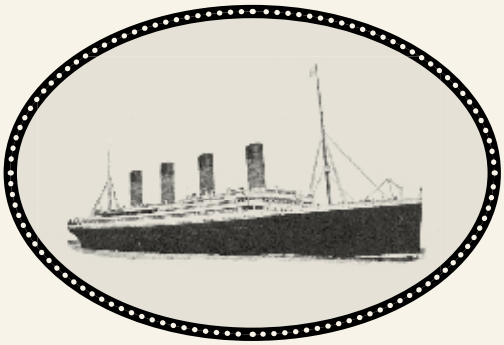
Role	Name
SCTS Honorary Treasurer	Mark Jones (commencing after completion of Annual Meeting March 2026)
SCTS Thoracic Surgical Tutor	Michael Shackcloth
SAC Chair	Timothy Jones

New Roles Congratulations to the following ...

Role	Name
SCTS Honorary Treasurer	Karen Redmond (commencing after completion of Annual Meeting March 2026)
SCTS Fund Raising Lead (Cardiac)	Cha Rajakaruna
SCTS Fund Raising Lead (Thoracic)	Giuseppe Aresu
SCTS Transplantation Co-Chair	Stephan Schueler
SCTS Equality, Inclusion & Diversity Co-Chair	Vipin Zamvar
SCTS Thoracic Surgical Tutor	Nathan Burnside
SAC Chair	Mark Jones
SCTS Deputy Audit Cardiac Lead	TBC
SCTS Research Cardiac Lead	TBC
SCTS Research Thoracic Lead	TBC
SCTS Research Medical Student Representatives	TBC

SCTS

ANNUAL DINNER 2026



DATE

Monday 16th March
18:30 - 00:30

LOCATION

Titanic Belfast, 1 Olympic Way
Belfast BT3 9EP

DRESS CODE

Black Tie / Cocktail Dress

TICKETS

£85 available online when registering for the SCTS Annual Meeting. Ticket includes welcome drink, tour of galleries, 3 course meal, wine, entertainment, and music.

scts.org

An Update from the SCTS Student Education Committee

Nikan Hoorijani, Medical Student, University of Glasgow
Donovan Campbell, Medical Student, Queens University, Belfast
Ethan Alford, Medical Student, University of Southampton
Benjamin Chapman, Medical Student, University of Oxford
Jason Ali, Consultant Cardiac Surgeon, Royal Papworth Hospital, Cambridge
Shilajit Ghosh, Consultant Thoracic Surgeon, Royal Stoke University Hospital

The SCTS Student Education Committee (formerly SCTS INSINC) would like to thank the outgoing committee and congratulate them for the incredible successes they achieved. We are delighted to welcome Mr Shilajit Ghosh, who joins Mr Jason Ali as Consultant Co-Lead, and we look forward to working together on upcoming initiatives. The new committee has been actively planning events and projects focused on promoting cardiothoracic surgery to the next generation and continuing the crucial ethos of widening participation. Stay up to date with the latest developments on our social media pages and the newly revamped SCTS website.

MedPrep

MedPrep is a programme aimed at inspiring sixth form students to apply to medical school and offering an insight into cardiothoracic surgery as a career. It combines in-person work experience opportunities with a national webinar series coordinated by the SCTS Student Education Committee. This has evolved from the INSIGHT programme developed by the previous committee.

The online component, led by Ananya, the current Widening Participation Lead, provided free, accessible online sessions for sixth form students interested in pursuing medicine and surgery, with a particular focus on cardiothoracic surgery.

Over the course of a week, speakers from medical students to consultants delivered sessions on medical school applications, introductions to cardiac and thoracic surgery, stages of training, and an interactive case on aortic stenosis. With around 80 participants and consistently positive feedback, MedPrep continues to deliver early exposure to cardiothoracic surgery while upholding the SCTS commitment to equal opportunity and outreach.

Looking ahead, the committee aims to expand the in-person work experience element to a multi-centre programme across the UK and Ireland. Those at any level of training interested in supporting or leading sessions at their local centre are encouraged to stay up to date via our social media for further information.

National Audit

The committee is developing a student-led, multicentre national audit in collaboration with the senior executive committee. Two project proposals, one in cardiac surgery and one in thoracic surgery, are under review to determine feasibility and educational value. The audit provides an opportunity for students to gain early exposure to collaborative clinical research in cardiothoracic surgery. Further details, including project selection, were announced at the Student Engagement Day, marking the official launch of this national initiative.

Great Britain and Ireland Cardiothoracic Mentorship Scheme

The committee is delighted to announce the relaunch of the Great Britain and Ireland Cardiothoracic Mentorship Scheme. This national programme provides early, structured guidance for medical students aspiring to a career in cardiothoracic surgery. Each student is paired with a dedicated mentor, ranging from senior trainees to consultants, to receive tailored support in career development, portfolio building, and insight into the realities of surgical training.

The scheme is conducted primarily online to ensure accessibility across all regions, with optional in-person mentorship where feasible. Previous cohorts have reported excellent feedback, highlighting the value of mentorship in demystifying the training pathway and fostering long-term engagement with the specialty.

Applications were opened via the SCTS newsletter, and we warmly invite surgeons and trainees to join the mentorship programme, an opportunity to share experience, shape future colleagues, and help cultivate the next generation of cardiothoracic surgeons.

Digital Educational Events

Building on the success of previous educational series, the committee continues to deliver high-quality sessions for aspiring surgeons. The *Getting into Cardiothoracic Surgery* series has returned, offering students across GB&I practical guidance on entering this competitive specialty and insight into the life and training of a cardiothoracic surgeon. Running alongside the mentorship programme, it aims to demystify the pathway and support students at every stage.

The SCTS Journal Club has also resumed, featuring expert-led discussions of key papers and innovations in cardiothoracic surgery to promote academic curiosity and evidence-based learning.

Looking forward, the committee plans to expand its educational reach globally, creating new opportunities for students in low-and-middle-income countries, beginning with Cameroon.

Regional Leads

The committee has established a nationwide network of Regional Leads across the 35 Universities in the UK and Ireland to enhance student engagement with SCTS and the specialty of cardiothoracic surgery. Each Regional Lead represents their medical school, facilitating communication between the committee and the wider community. This structure allows for the effective dissemination of information, resources, and educational opportunities. Through this initiative, the committee aims to provide structured support for medical students interested in cardiothoracic surgery by fostering early involvement and ensuring accessible points of contact across the country.

Equality, Diversity and Inclusion (EDI)

The committee remains committed to continuing the excellent work of the previous team on the Equality, Diversity and Inclusion Survey. With guidance from the SCTS Executive Committee, the 2025–2027 iteration of the survey has been updated using insights from the 2023–2025 cycle. The latest version was launched at the SCTS Student Engagement Day in November.

Sponsors

We are deeply grateful for the continued support of our sponsors, whose generosity enables initiatives that benefit the next generation of cardiothoracic surgeons. We look forward to maintaining these valued partnerships and building new collaborations in the years ahead.

Medtronic MDU Concentric

Student Elective Bursary

Through the immense generosity of sponsors, two students recently completed elective placements in cardiothoracic surgery as part of the SCTS Student Elective Bursary Scheme. We thank both Concentric Health and the Medical Defence Union (MDU) for their kind sponsorship. Keep an eye out for upcoming elective bursaries in 2026.

Student Engagement Day

The 2025 Annual Cardiothoracic Surgery Student Engagement Day was hosted by Keele University in Newcastle-under-Lyme. This interactive and inspiring event brought together students and surgeons from across the UK and Ireland for a day of teaching, discussion, and hands-on experience.

SCTS Medical Student Day 2026

We are delighted to announce that the Annual Student Day will be held on Sunday 15 March 2026 as part of the SCTS Annual Conference. This will be another exciting occasion featuring insightful talks from surgeons, wet-labs offering hands-on experience of surgical techniques, and the opportunity to present at the Pat Magee Research Session for the prestigious Pat Magee Prize. ■

@SCTS_STUDENTEDUCATION

Reducing Surgical Site Infection Using Several Novel Interventions, the ROSSINI-Platform trial: Cardiac Surgery Pillar

Mohammed Islam, Senior Clinical Research Practitioner, Guys and St Thomas NHS Trust
Judith Tanner, Professor of Adult Nursing, University of Nottingham
Melissa Rochon, NAHP, Harefield Hospital, Middlesex
Luke J Rogers, NTN, James Cook University Hospital, Middlesbrough
Ricky Vaja, NTN, Royal Brompton Hospital, London
On behalf of the ROSSINI-Platform Investigators Collaboration

The ROSSINI-Platform trial is a multicentre, basket factorial multi-arm, multi-stage (MAMS) platform randomised control trial (RCT) to evaluate the use of multiple interventions to reduce surgical site infection (SSI) across several types of surgery.

The call never sounds dramatic. A week or two after discharge, a patient rings a secretary or uploads a photo: a red line along the sternum, a patch of gauze that keeps spotting through, a sentence that begins, "I'm sure it's nothing, but…" For years, these moments lived outside our line of sight. They were handled in community clinics or A&Es, and only sometimes found their way back into an M&M slide. We congratulated ourselves on shorter lengths of stay, while never quite seeing what happened after they went home.

Every cardiac surgeon knows the other scene: the ward round after a weekend on call, the dressing taken down, the hush that follows. It's rarely our patient. The scrub team wonders whether gowning was done in a rush. The nurses coax a reluctant vacuum dressing into sealing. The patient looks up and asks the one question that matters: "Why me?"

We talk about surgical site infections (SSIs) as if they're rare. They're not. SSIs remain the most common hospital-acquired infection in the UK. After sternotomy, they carry a tenfold increase in mortality, a sixfold increase in readmissions, and are a major contributor to prolonged ICU stays. What's more troubling is how many go undetected by surgical teams, declared in primary care, urgent treatment centres or late-night A&E visits, and never linked back to theatre. Nearly a quarter of patients are readmitted to a different hospital entirely. It's not because we don't care – it's because our systems aren't built for follow-up.

That's what led to the development of the cardiac pillar of the ROSSINI-Platform, the largest surgical trial in the UK, a multi-arm, multi-stage (MAMS) trial sponsored by the University of Birmingham and coordinated by the Birmingham Clinical Trials Unit (BCTU). It builds on the successful ROSSINI Trials 1 and 2 in colorectal surgery and aims to evaluate a set of pragmatic interventions to reduce SSIs in cardiac surgery.

The cardiac pillar is designed to be as close to real-world practice as possible. The aim is to include the kinds of patients we see every day. Any adult having elective, urgent

> "This low-burden, digital-first approach aims to keep patients engaged beyond discharge and improve the post-discharge SSI detection in real time. It's not just about data; it's about getting a clearer picture of outcomes we currently miss."

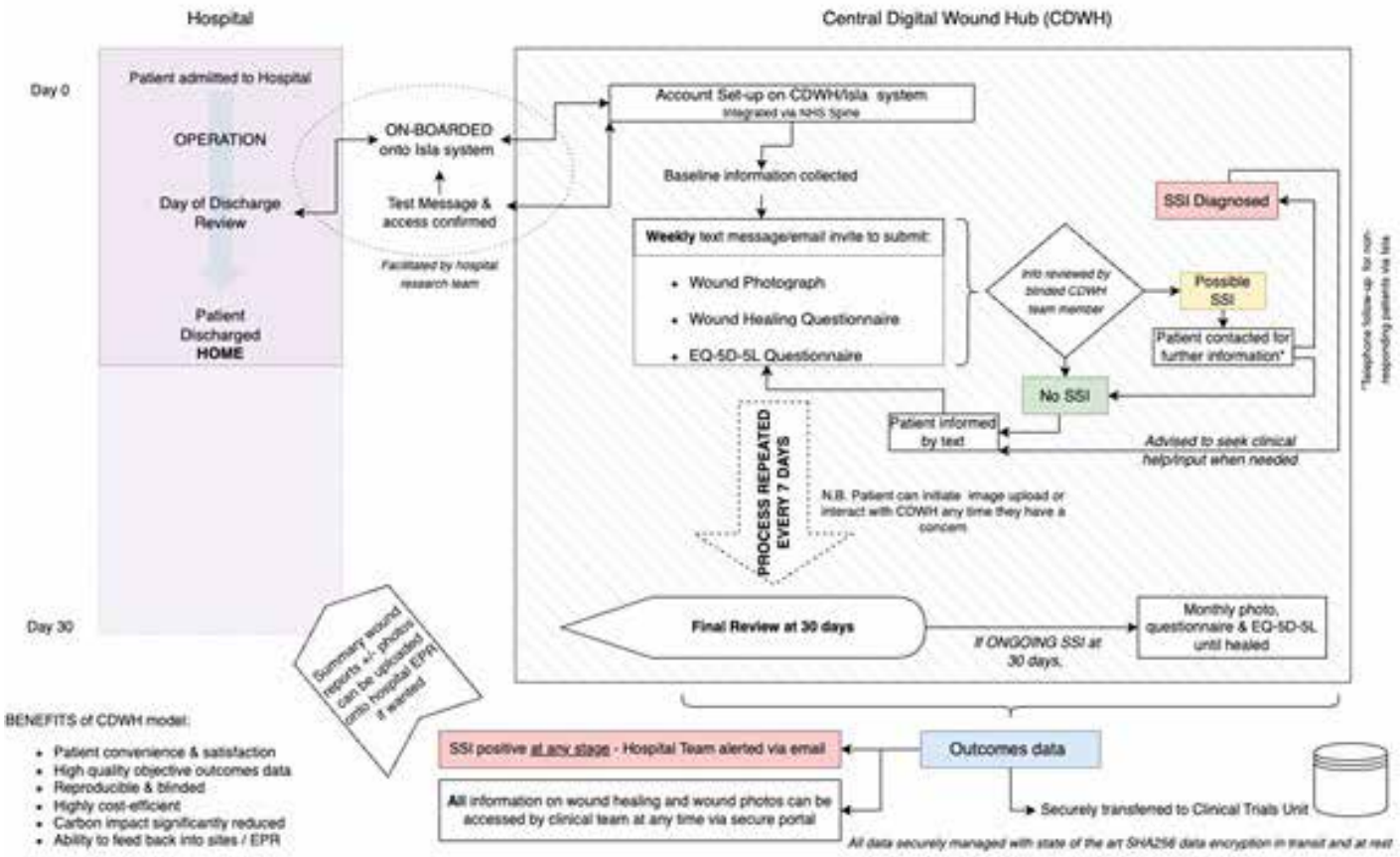


Figure 1. Validated telemedicine tool for blinded remote SSI diagnosis for all surgical pillars through a pre-existing and dedicated central digital wound hub (CDWH).

or emergency cardiac surgery via median sternotomy can be included if they can give consent and have access to a phone or email for follow-up. We've excluded patients with active endocarditis and an open sternal wound.

The interventions being tested in the cardiac surgery pillar are:

- Glove and instrument change before chest closure,
- Use of a gentamicin collagen sponge in the sternal wound prior to closure and,
- A negative pressure wound therapy dressing prophylactically applied after skin closure

Participants are asked to submit weekly wound photographs and brief questionnaires via text or email using the Isla platform. They can nominate someone to do this on their behalf if desired. Submissions can also be initiated by the patient / carer if they notice a change in the wound in between submissions. All submissions will be reviewed by the Central Digital Wound Hub (CDWH), a dedicated specialist team for wound care and monitoring, based at Guy's and St Thomas' NHS Foundation Trust. If a possible SSI is detected, the participant's local clinical team will be notified. Teams will also be able to access their patients on Isla to review as necessary.

This low-burden, digital-first approach aims to keep patients engaged beyond discharge and improve the post-discharge SSI detection in real time. It's not just about data; it's about getting a clearer picture of outcomes we currently miss.

Over 25,000 patients will be recruited across 100 NHS hospitals with sample sizes set per pillar, based on baseline SSI rates and projected risk reductions. For cardiac surgery, the target is 3,764 participants.

This update is shared on behalf of the Cardiac Interdisciplinary Research Network (CIRN) to inform and encourage engagement across the speciality. We believe the ROSSINI-Platform gives us an opportunity to move from retrospective "too little, too late" audit to real-time learning and intervention. Improving the systems around us, not just the surgery itself. If you'd like to learn more or explore how your unit can take part, please contact **CIRNetwork@outlook.com**.

We are especially interested in identifying Principal Investigators (PIs) and Associate PIs in the following hospitals:

- University Hospital of Wales
- St George's Hospital
- Newcastle upon Tyne Hospitals NHS Foundation Trust
- NHS Grampian (Aberdeen Royal Infirmary)

Recruitment will begin upon final ratification of the master protocol, and we want the cardiac surgery pillar to lead the surgical field. Join us!

On your next ward round, or the next time a patient sends in a photo of a wound that won't heal, ask yourself: what would it take for your team to act sooner? And what might you learn if you had the tools and support to do so, not after the fact, but while you could still make a difference ...? ■

Insights from the First Year of the National Consultant Information Programme (NCIP) in England: A Focus on Lung Resection

Doug West, NCIP Clinical Lead,
Consultant Thoracic Surgeon, Bristol Royal Infirmary

The First Year of Thoracic NCIP

December 2025 marks a year since NCIP data became available to all NHS consultant thoracic surgeons in England. This unique resource allows access to demographic, comorbidity and outcome data on the commonest thoracic operations, available without cost and updated quarterly. It is already available in many large surgical specialties including general surgery, orthopaedics and gynaecology. It is universal, which is to say that all NHS activity is included, and by using routinely collected data it avoids any need for clinicians to personally upload data.

Many of us are already using the information for our appraisal, revalidation or local QI. Although NCIP includes data on many elective and urgent thoracic procedures, in this article we will use the example of lung resection to highlight the insights available.

NCIP breaks down lung resections into pneumonectomies, (bi)lobectomies, segementectomies and wedge resections. In 2024-25, 6875 lobectomies were performed, along with 3546 segmentectomies, 915 wedge resections and 658 pneumonectomies.

> **"With NCIP data updated quarterly, it offers the most up to date numbers on the continued development of minimal access lung resection."**

Lung Resection, the Data

Mortality risk is central to informed consent. In 2024-25, we are seeing lower 90-day all-cause mortality compared to the pre-pandemic era, with 1.8% of lobectomies, 1.9% of wedge resections and 1.5% of segmentectomies not surviving 90 days after surgery. For comparison, the equivalent figures for 2017-2020 were 3.1%, 2.5% and 1.8%.

Thoracic surgery has been proactive in adopting day of surgery admission, but there is still significant variation between units across the country (from no patients to 99% of patients admitted on the day of surgery). On average, 58% of all lobectomy and segmentectomy patients were able to sleep at home on the night before their surgery.

Activity continues to rise every year, a trend that began in the mid-2000s. Proportionally, it is sublobar resections that are growing the fastest, by 34.4% and 26.9% for segmentectomies and wedges respectively between 2022-23 and 2024-25. The equivalent increase for lobectomy was only 17.1%, although it remains the commonest operation.

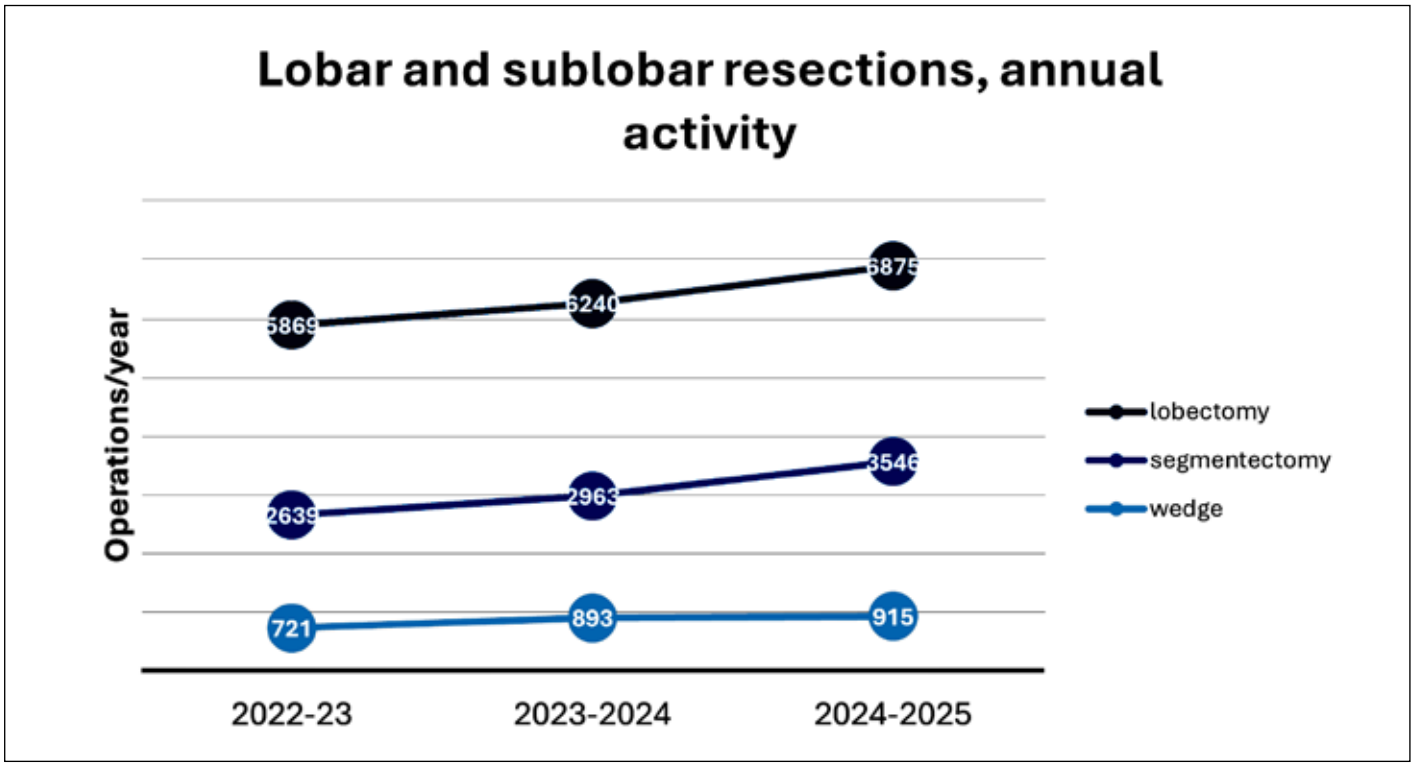
Because NCIP includes all NHS activity, we can easily extend our understanding of outcomes beyond hospital discharge.

A Focus on Lobectomy

NCIP also offers comorbidity and demographic metrics. For example, 58% of 6875 lobectomy patients in 2024-25 had a calculated Charlson Comorbidity Score of 2 or above. The median age was 70 and there was a slight trend towards more socioeconomic deprivation, with 23.7% living in lowest quintile deprivation index areas.

Outcomes after Lobectomy and Sublobar resections (all pathologies) 2024-25

	Upper quartile length of stay	90-day readmission	90-day mortality	Day of surgery admission	In hospital acute kidney injury
Lobectomy	7	16.2%	1.8%	58.%	5.28%
Segmentectomy	6	11.6%	1.5%	58.3%	3.8%
Wedge	5	11.8%	1.9%	73.1%	2.4%



Minimal Access Development

With NCIP data updated quarterly, it offers the most up-to-date numbers on the continued development of minimal access lung resection. 82% of all 2024-25 lobectomies were performed by minimal access approaches, 24% using the robot. For segmentectomies the minimal access rate was even higher at 90%, with 27% done robotically.

The introduction of robotics has been remarkably fast. As recently as 2017-20, only 2% of lobectomies and 3% of segmentectomies were performed with robotic assistance.

In subsequent articles I hope to provide insights on other areas of practice using NCIP. In the meantime, there is no need to wait for the next Bulletin, you can go online right now and see all this data and more for yourself. This includes your own personal data, and individual unit data. It is up to date, comprehensive and free. If you need a password or want us to talk through NCIP online to your unit, just let me know. ■

With thanks to Claire Groves, NCIP Senior Deployment & Adoption Manager.

New Appointments August 2025 to January 2026 ...

Name	Hospital	Specialty/Role	Starting Date
Ahmed Al-Adhami	Queen Elizabeth Hospital, Birmingham	Locum Consultant Cardiac Surgeon	October 2025
Ahmed El Zeki	University Hospital of Southampton	Locum Consultant Thoracic Surgeon	October 2025
Saif Mohamed	Royal Sussex County Hospital, Brighton	Substantive Consultant Cardiac Surgeon (Mitral)	October 2025
Rebecca Weedle	St James' Hospital, Dublin, Ireland	Substantive Consultant Cardiothoracic Surgeon (Thoracic Surgical Oncology)	October 2025
Ahmed Osman	Royal Brompton Hospital	Locum Consultant Thoracic Surgeon	November 2025
Vanessa Rogers	Royal Papworth Hospital	Locum Consultant Thoracic Surgeon	November 2025
Sudeep Das De	Aberdeen Royal Infirmary	Locum Consultant Cardiac Surgeon	December 2025

Shared Priorities, Shared Progress: Moving Training Forward

Ali Ansaripour, SCTS Junior Trainee Representative, NTN, John Radcliffe Hospital, Oxford
Mohamed Sherif, SCTS Senior Trainee Representative, NTN, Northern General Hospital, Sheffield
On behalf of the NTCCTS

The past year has seen continued progress in several areas of cardiothoracic training, supported by constructive engagement between trainees, trainers and national organisations. The National Trainee Committee for Cardiothoracic Surgery (NTCCTS) has remained closely involved in this work, with a focus on improving the early years of training, ensuring preparedness for evolving clinical practice, and supporting smooth transition into consultant roles.

Recent curriculum development, which involved sustained collaboration between the SAC and the trainees, is now progressing through GMC approval. The revised curriculum is expected to provide clearer alignment with modern cardiothoracic practice, and we look forward to contributing to implementation planning in the year ahead.

Strengthening Phase 1 (ST1–3)

Phase 1 accounts for approximately 42% of run-through training, yet the structure and experience of this stage vary considerably. Findings from our recent trainees' survey highlighted differences in access to protected operative time, consistency of cardiothoracic-focused placements, and opportunities to develop continuity of care through MDT and outpatient involvement.

Following discussion at the recent SAC meeting, a Phase 1 subcommittee has now been established to take forward work in this area. This group will work with the SAC Chair and the national Phase 1 lead to outline guidance that supports early training environments with regular time in theatre, meaningful participation in perioperative decision-making, and external placements selected for their educational relevance to cardiothoracic practice. This work is now underway, and we will continue to contribute to its development and keep trainees updated as it progresses.

Minimally Invasive Cardiac Surgery and ERACS

The national expansion of minimally invasive cardiac surgery (MICS) and enhanced recovery pathways represents an important development in cardiac surgical practice. These changes are likely to influence the structure of surgical teams, case selection and perioperative pathways in the years ahead. It is therefore essential that training evolves in parallel, ensuring that trainees have structured opportunities to develop the technical and decision-making skills required for these approaches. We are engaging with ongoing planning discussions to support the incorporation of simulation, wet-lab training and supervised exposure into training pathways as MICS becomes more widely adopted. The aim is to ensure that future consultants are equipped to deliver these techniques safely and confidently, and that training progression aligns with changes in operative practice.

Broadening Access to Subspecialty Experience

Access to subspecialty experience – such as congenital surgery, transplantation and complex thoracic or cardiac surgeries – varies across training regions. Work is currently underway within the SAC to explore partnership models between deaneries that would provide clearer and more consistent routes for trainees who require experience in these areas to meet curriculum outcomes. This work is still in development, and options are being reviewed carefully to ensure that any approach remains fair, transparent and compatible with service capacity. Once draft proposals are available, they will be shared with trainees for consultation and feedback.

FRCS Examination Access

Lack of access to the FRCS Section 2 examination has been a long-standing concern for senior trainees. We are pleased to note that recent expansion in examination capacity – particularly through the London examination diets – has contributed to a reduction in waiting times. We are grateful to the JCIE chair, examiners and local organisers for their work in achieving this. Our aim is to collaborate with JCIE to enhance trainees' accessibility to the examination process, thereby supporting timely training progression and CCT.

Post-CCT Progression

Understanding post-CCT progression is essential to ensuring that trainees are well prepared for consultant practice. We have therefore begun work to map recent post-CCT pathways, including fellowship destinations and consultant appointments. The purpose of this work is to provide clearer information for trainees approaching completion of training and to support ongoing alignment between training structure and service needs.

Looking Ahead

The direction of travel is one of steady, structured improvement, guided by evidence and shaped by shared priorities. We will continue to support national discussions in these areas and provide updates as work progresses. ■

LONDON TO BRIGHTON CYCLE RIDE

JOIN TEAM SCTS!

After the success of our 1st event, SCTS will again tackle the London-Brighton Cycle Ride on **Sunday 13th September 2026.**

We invite you to join TEAMSCTS, making Heart, Chest & Lung Surgery better.

Registration is now open!

This is not just a sporting challenge; it is a public statement of our values – aiming high, teamwork, resilience, and an unshakable drive to deliver better patient outcomes. Your support – whether through donation, support or advocacy– will help turn our vision into action. Together, we can ride further, achieve more, and make a lasting difference.

Registration Fees:

£55 per person for fully supported ride
(£35 trainees and £20 students)

For more information visit www.scts.org or scan the QR code.

MAKING HEART, CHEST & LUNG SURGERY BETTER!

Thoracic Surgery in the UK: Trends, Insights, and Future Discussions

Nathan Burnside, Consultant Thoracic Surgeon, Nottingham City Hospital
Kandadai Rammohan (K S Rammohan), Consultant Thoracic Surgeon, Wythenshawe Hospital, Manchester

Ram and Nathan are proud to present the National Returns Data for 2023-2024 on behalf of the Audit Subcommittee. This report presents an analysis of thoracic surgery trends in the UK based on the National Returns Data for 2023/2024, encompassing procedures related to primary lung cancer and secondary malignancies. Whilst limited in scope, the data offers insights into the increasing adoption of minimally invasive techniques since the last Blue Book publication. It shows the persistence of open surgeries for complex cases, and highlights a few key challenges facing the surgical community.

Primary Lung Cancer

Looking firstly at primary lung malignancies, a total of 9,413 surgical resections were performed. Open surgery accounted for 1,955 cases with 44 deaths, resulting in a mortality rate of 2.25%. VATS was the most common approach, with 5,150 cases and 43 deaths, yielding a mortality rate of 0.83%. RATS treated 2,308 patients with 21 deaths, reflecting a mortality rate of 0.91% (Figure 1).

Over the last seven years we have seen a significant shift in surgical approaches, with robotic-assisted thoracic surgery (RATS) becoming increasingly prevalent. Since 2017/2018, the number of RATS procedures increased from 134 to 2,380, marking an 18-fold rise. Meanwhile, video-assisted thoracic surgery (VATS) saw a 7% increase, from 4,784 to 5,150 procedures, still the dominant procedure for the management of primary lung cancer. In contrast, open surgeries decreased by 42%, from 3,378 to 1,955. This decline has halted over the last four years and has remained fairly static.

Despite the rise of minimally invasive techniques, open surgeries remain critical for specific procedures. The data shows that 77% of chest wall resections, 81% of sleeve resections, and 99.2% of pneumonectomies were performed through an open approach. The persistence of open surgeries underscores their importance in managing challenging cases. With some centres achieving minimally invasive rates of 95% and a median rate of over 80%, there is the potential for some open skills to be lost or limited to a few.

With the Violet study confirming minimally invasive approaches have reduced pain, a better post operative quality of life, a shorter hospital stay and lower complication rates amongst others, we should be celebrating this achievement. However, the variability across the UK is significant with some areas over two standard deviations from the mean (Figure 2).

There is also significant variability when choosing which procedure to perform with some units reporting high rates of wedge resection for primary lung cancer. SCTS report an average rate of 13.7% across all units, with a standard deviation of 9.2, with one unit reporting a wedge rate of 0.71% and another reporting 35.7%. Despite the evidence from JCOG0802 and CALGB140503 presented over a year prior to the collection of this information, no change in national trends towards wedge resection have been seen.

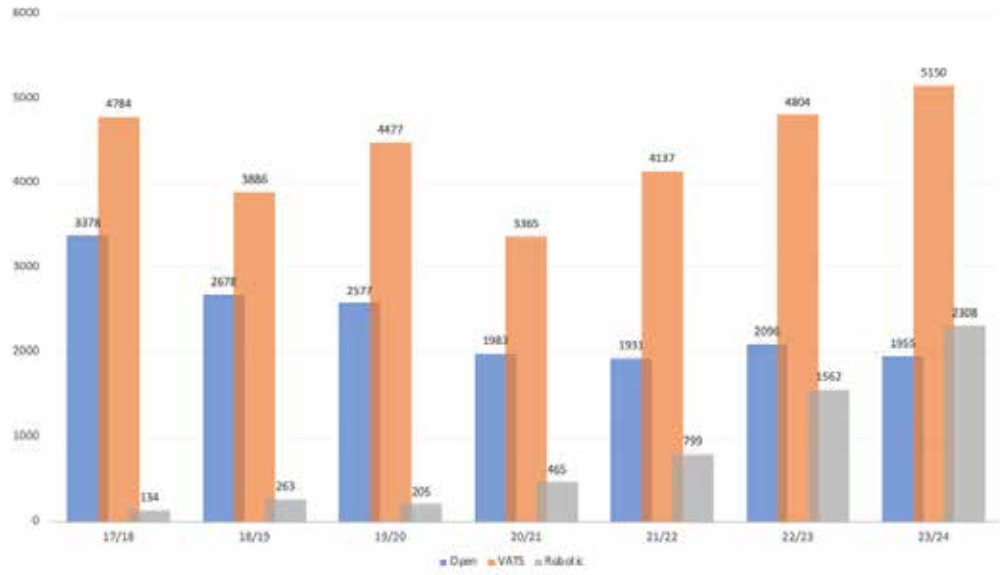


Figure 1

Resections for Secondary Lung Cancer

The National Returns Data reports 3,157 operations for secondary malignancies in the lung, with VATS being the most common approach (2,167 cases), followed by RATS (462 cases) and open surgeries (528 cases) of these, 575 were lobectomies.

A standout datapoint is that no-one died from a robotic lobectomy for secondary cancer this year (the overall mortality of 0.18% in all resected secondary cancer) which implies that perhaps the metastatectomy argument should change from who would benefit from an operation to who shouldn't have their metastasis resected?

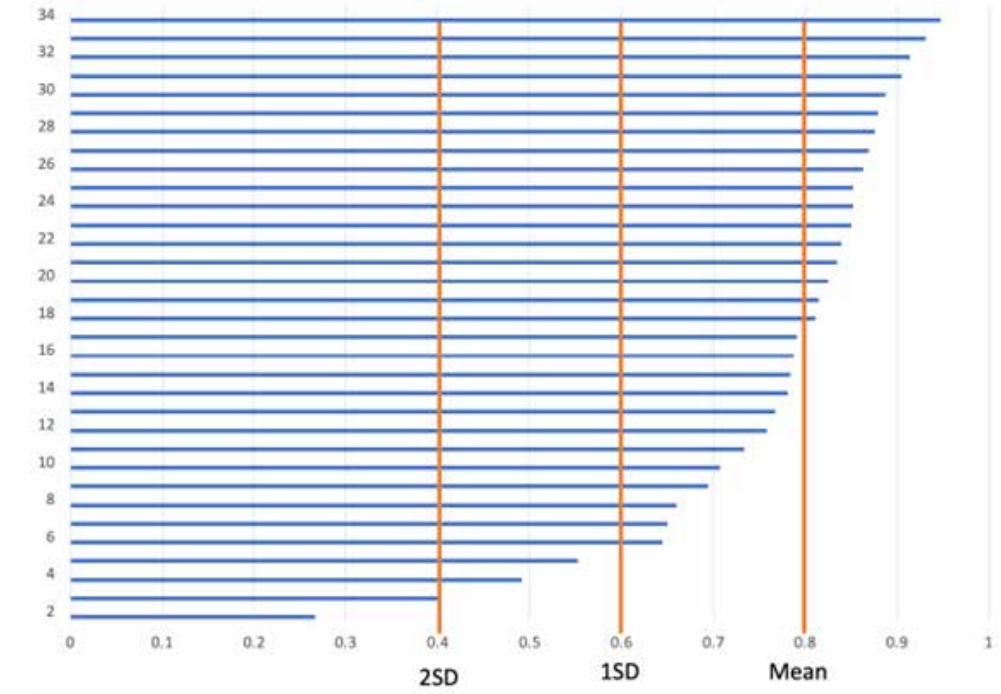


Figure 2

National Database

To further strengthen the safety we can provide to patients undergoing thoracic surgery the SCTS has relaunched a plan for a national database. We would expect this to allow for the advancement of patient care through enhancing the analysis of clinical outcomes, and in driving innovation in surgical techniques. A comprehensive database would collect and analyse data from all thoracic surgical procedures across the country, providing a robust evidence base for informed decision-making.

A national database enables continuous monitoring of surgical performance, allowing for benchmarking across institutions. Outcomes can be accurately reviewed in a transparent way, encouraging best practices. Identifying variations in practice can highlight areas for improvement and drive standardisation, ensuring consistent, high-quality care nationwide.

The database would also support clinical research and innovation. Large-scale, real-world data on procedures like VATS, RATS, and open surgery would facilitate studies on surgical techniques, patient selection, and long-term outcomes. This evidence base would accelerate the adoption of minimally invasive approaches while confirming the role of open surgery in complex cases. Nationally gathered data could also validate emerging techniques and technologies, ensuring that advancements are safely and effectively integrated into practice.

You may be aware that this has been attempted before and so a long period of engagement with each unit will be needed but we firmly believe that establishing a national database for thoracic surgery in the UK would be a transformative step, fostering a culture of excellence and ensuring optimal patient outcomes across the country.

This needs to be an all-inclusive project and we want all teams to be involved. Any patient safety impact or publication from this project would be attributable to those involved and not linked to just a few people. If you wish to be involved in the project, please contact Ram or Nathan on the details below. I'd like to thank everyone who has been involved in this project to date and am excited to see the future of patient care in the UK and Ireland being improved.

In the meantime, there have been discussions at an executive level to provide a factual reporting of the returns to each individual unit. These are simple reports comparing the unit to national averages, they would not be risk adjusted, and are merely there to give each unit an insight to where they are as thoracic surgery develops in the UK and Ireland. ■

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nburnside@doctors.net.uk
Kandadai Rammohan:
Kandadai.rammohan@mft.nhs.uk

"A national database enables continuous monitoring of surgical performance, allowing for benchmarking across institutions. Outcomes can be accurately reviewed in a transparent way, encouraging best practices."

Surgical Leadership in Management (SLIM) for Cardiothoracic Surgery: Developing the Next Generation of Surgical Leaders

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

On 18 September 2025, the Royal College of Surgeons of England (RCS England) hosted the inaugural Surgical Leadership in Management (SLIM) for Cardiothoracic Surgery course – a collaborative event organised by the Society for Cardiothoracic Surgery (SCTS), RCS England and the Association of Surgeons of Great Britain and Ireland (ASGBI).

Designed specifically for Clinical Directors and Clinical Leads, the course offered a practical, honest and forward-looking exploration of what it takes to effectively lead a Cardiothoracic Surgery Department within the modern NHS – balancing service delivery, patient safety and staff wellbeing, while managing growing administrative and financial pressures.

A Collaborative Approach to Leadership

It was a pleasure to be joined as Course Director by Professor Gill Tierney, past President of the ASGBI and the driving force behind the SLIM course, and Ralph Tomlinson, Director of Research and Quality Improvement at RCS England. The principles of the SLIM initiative represent a cultural shift in surgical leadership, moving away from the traditional model of an authoritarian leader towards one that is collaborative, inclusive and team-based, grounded in integrity, compassion and communication, and with an emphasis on shared accountability rather than hierarchy. This philosophy underpinned the day's agenda, which combined insight from experienced clinical directors, national programme leads and experts in healthcare improvement and regulation.

Understanding the Challenges and Changing Culture

Following opening presentations by Narain Moorjani & Gill Tierney to introduce the SLIM principles, the morning session of the course discussed the evolving responsibilities of surgical leaders. The delegates explored the delicate balance between clinical excellence and the demands of managing teams, budgets and institutional expectations.

During the first presentation, Mark Cheetham drew on his extensive leadership experience as a Divisional Director, as well as work with the GIRFT programme, to discuss the role of a Clinical Director. Strategies for balancing competing priorities, from service delivery and workforce pressures to governance, safety and resource allocation, while maintaining personal resilience and integrity, were presented. It provided the delegates a candid insight into the realities of managing a surgical department in the current environment.

In the second presentation, which focussed on the effective introduction of change, Katie Adams explored the psychology of organisational change, highlighting the importance of clarity, communication and inclusion. She outlined practical strategies for overcoming resistance and ensuring that innovation translates into sustainable improvement. It was clear to see that successful change in surgical services requires not only a strong vision but also empathy, patience and the ability to bring people along on the journey.

Financial literacy is an often overlooked but essential component of surgical leadership. In Mike Goodwin's presentation, he offered delegates valuable insights into NHS finance and resource management. He encouraged clinicians to engage proactively with Trust finance teams and to view budgets as opportunities to align financial stewardship with clinical priorities, rather than constraints on innovation.

Supporting Colleagues and Upholding Standards

The morning concluded with a thought-provoking talk on the General Medical Council referral process and compassionate regulation. Representing the GMC, Anna Bailey discussed the emotional toll of regulatory processes on clinicians and outlined the GMC's commitment to more compassionate, transparent and proportionate approaches to oversight. The session encouraged open dialogue around protecting both patient safety and clinician well-being within a culture of accountability and learning.

During the open Q&A session, it was clear to hear that leadership cannot be separated from the culture in which it operates. Creating psychologically safe, respectful environments was identified as essential for both patient safety and staff morale. The presenters shared practical approaches to cultivating positive cultures, including inviting challenge, listening without defensiveness and modelling the behaviours expected from the wider team. The delegates engaged in discussion about the need for mentorship, peer support and structured leadership training to support those in senior roles.

It was interesting to hear the range of challenges encountered by delegates in their respective leadership roles – some specific to their individual departments, yet many shared across units due to the

broader circumstances of the current healthcare environment. It was a pleasure to welcome participants from cardiothoracic surgical units across the country, including several senior Clinical Directors, who contributed valuable insights drawn from their own leadership experience, along with practical strategies for navigating the complexities of the role.

The afternoon session was opened by Tim Mitchell, President of RCS England, who presented on leadership from a Royal College perspective. He reflected on leadership as a shared professional duty rather than an individual status and recounted stories of his journey in surgical leadership. His message echoed the themes of the day that effective leadership is learned, nurtured and underpinned by authenticity and service. He reiterated the College's commitment to supporting surgeons in leadership roles and developing structured training to prepare future leaders.

Delegates and faculty at the inaugural Surgical Leadership in Management (SLIM) Cardiothoracic Surgery course, held at the Royal College of Surgeons of England, September 2025

The day's final session led by Ralph Tomlinson and Rana Sayeed, featured an interactive workshop on the Invited Review Mechanism (IRM), a process designed by RCS England to support Trusts and clinicians in addressing complex professional or service concerns. Through case-based discussion, participants explored when and how to utilise the IRM, lessons learned from previous reviews and best practices for supporting colleagues in difficulty. Topics included managing conflict within teams, addressing performance concerns and maintaining professionalism under pressure.

The day concluded with a drinks' reception, allowing delegates to continue networking and share reflections from the sessions.

We would like to thank the faculty and delegates for contributing to a day characterised by openness, collaboration and optimism. We would also like to pass on our gratitude to Jill Hart, Mara Banuta and Emma Piotrowski for their fantastic organisation and administration of the course. We are also deeply indebted to Professor Gill Tierney and the SLIM Steering Group for bringing the SLIM course to Cardiothoracic Surgery, and Ralph Tomlinson & Tim Mitchell for their generosity for hosting the course at the Royal College of Surgeons of England.

Whilst leadership in cardiothoracic surgery carries significant responsibility, it also offers immense opportunity, to shape culture, advocate for teams and influence patient outcomes far beyond the operating theatre. ■

Kindling the Flame: My Elective in Cardiothoracic Surgery

Tai-ba Hassanian, Medical Student, University of Auckland

It was Socrates who argued that *"education is the kindling of a flame, not the filling of a vessel."* I like to think that Socrates was shedding a light on how learning is not about simply isolated to absorbing knowledge. Rather, igniting a curiosity, a spark that students themselves carry forward through a lifelong pursuit of knowledge.

My name is Tai-iba Hassanian, and I'm a final-year medical student at the University of Auckland. Recently, I had the privilege of spending eight weeks at the Royal Infirmary of Edinburgh, training with the wonderful team in the Cardiothoracic Department. For me, this experience has undoubtedly fanned the flames of curiosity and has sharpened my focus on the direction of medicine I would like to head towards.

The Road to Edinburgh

I had always been eager to spend part of my training abroad. So, when it came time to arrange our electives here in New Zealand, I took a stab in the dark and reached out to Mr Vipin Zamvar, a Consultant Cardiothoracic Surgeon based in Edinburgh. Hearing about the positive experiences of other students who had trained there, I could hardly contain my excitement when Mr Zamvar offered me a placement in his department.

Before setting off on this new chapter, I was still uncertain about pursuing a career in surgery. With a 30-hour journey from New Zealand to the UK ahead of me, I had plenty of time to wrestle with my doubts on the plane. Did I really have what it takes to become a surgeon? Would I fit into the fast-paced rhythm of theatre life? Would I be able to balance surgery with the rest of my life? Those doubts quickly faded the moment I stepped into the operating theatres in Edinburgh.

Embracing the Operating Theatre

Mr Zamvar quickly became a mentor to me in the truest sense of the word. Despite the unrelenting demands of theatre, clinics, and paperwork, he consistently made time to teach me. He even took it upon himself to try to teach me how to drive clutch using his daughter's car – hoping I might explore Scotland more freely.

One moment that stands out vividly occurred early on, when Mr Zamvar asked if I knew how to hand-tie sutures. I hadn't tied a surgical knot in what felt like years, but I gave it my best attempt. "No, that's how we tie shoelaces," he said with a smile, before walking me through each step. Despite it being the end of a long day in theatre, he didn't rush me. He let me practice until the motion became second nature. Before I left, he handed me a bundle of silk sutures to take home, gently reminding me that learning doesn't end in the operating room. I walked out of theatre that evening with a spring in my step, feeling a little more competent and a great deal more inspired. With Mr Zamvar's guidance, I found myself assisting with the closure of saphenous graft sites, refining my suturing technique, and receiving thoughtful feedback that helped me consolidate my knowledge.

Tai-Ba Hassanian & Vipin Zamvar

The View from the Stool

"Can we please get a stool for the medical student?" It was a daily phrase I quickly became fond of. Each time I heard it, I felt encouraged to take up space in theatre as a student. I was often ushered to the head of the bed, next to the anaesthetist – a spot that felt like the front-row seat in cardiac surgery.

During my time in the theatre, I observed a range of intricate operations, from aortic and mitral valve replacements to coronary artery bypass grafts, robotic-assisted lung resections, and biopsies. I'll never forget the first time I witnessed cardioplegia being administered. I remember holding my breath as the patient's heart, once beating vigorously, fell completely still within seconds. Watching the team in motion – the surgeons, anaesthetists, scrub nurses, and surgical care practitioners – was like witnessing a carefully orchestrated performance, where every movement served a purpose. The SCPs, in particular, left a strong impression. Coming from New Zealand, where this role doesn't yet exist, I was struck by the valuable part they played in the surgical workflow. More than that, they were generous with their time, sharing practical insights, encouraging questions, and creating a space where I could contribute.

Looking Ahead

By the end of the two months, the cardiothoracic department had not only challenged me but truly inspired me to strive for a career in surgery. Mr Zamvar's mentorship was exceptional. His patience, expertise, and genuine dedication make him a credit to his profession and an exemplary teacher, one I feel deeply honoured to have learned from. Amongst all the exams and assessments of medical school, it's easy to lose sight of what an extraordinary and deeply privileged profession medicine is. This placement was a timely reminder of that, and has invigorated my sense of purpose as I begin my career as a junior doctor. ■

From Fragmentation to Coordination: Implementing the Pan-London Referral, Transfer and Escalation Pathway for Acute Aortic Dissection

Dr Farhin Holia, Research Fellow, Royal London Hospital
Professor Aung Oo, Consultant Cardiac Surgeon
On behalf of the North London Acute Aortic Dissection Steering Committee and the Pan-London Acute Aortic Dissection Workstream

Every Reform Begins with Failure

For London, it was the repeated loss of patients with acute aortic dissection (AAD) when every regional centre was full, and no one claimed responsibility. Registrars made multiple calls while the aorta continued to tear. The coroner's verdict was clear: London needed a single, accountable process for referral, transfer, and escalation.

Those moments exposed a structural truth: when ownership diffuses, systems slow, people withdraw, and patients pay the price.

The Unseen Architecture of Accountability

AAD is among the fastest-moving cardiovascular emergencies. Mortality rises by 1–2 percent per hour after onset (Bossone et al., 2023). The differentiator is not skill but coordination. Unlike trauma or stroke, the NHS lacked a unified referral pathway.

Led through the **Pan-London Acute Aortic Dissection Workstream**, the initiative set out to replace fragmentation with coordination and embed accountability across London's cardiac centres. The aim was not to write another protocol but to design a *system of responsibility* – one where everyone knew who owned the patient, the decision, and the next move.

Why Implementation Mattered Most

London already had excellence in individuals; what it lacked was alignment. Implementation meant dismantling years of local habit, informal escalation, and inconsistent communication.

In organisational terms, the system *lacked congruence* – alignment between structure, people, workflow, and shared purpose (Nadler & Tushman, 1980). Without it, even expertise could not yield reliability.

In emergency departments, registrars faced the same nightly dilemma: *Which centre should I call?* When capacity was exhausted, escalation defaulted to negotiation, not policy. The new **Pan-London Referral, Transfer and Escalation Pathways** (Type A, Type B, Non-A/Non-B) (Holia et al., 2025) replaced ambiguity with design:

- a single access route for referral
- a Primary Aortic Centre (PAC) accountable for coordination
- a continuum of responsibility – ownership moves forward with the patient, never back to the referrer

The Unseen Architecture of Accountability

Before 2025, escalation relied on goodwill; now it rests on governance. The diagnosing clinician initiates referral; the PAC retains responsibility until definitive care is secured; if capacity is exceeded, escalation to a partner centre or region is mandatory.

This converts responsibility from courtesy to system function. It exemplifies **tight-loose-tight governance** (Tushman & O'Reilly, 2022): tight on purpose and accountability, loose on local method, tight again on measurement.

The Human Side of Structure

Reform was behavioural as much as procedural. Surgeons, anaesthetists, and emergency physicians had to unlearn defensive communication and adopt shared language. Historically, referrals began with *"Can you take this patient?"* The new framing – *"How do we get this patient to definitive care safely?"* – embodies **psychological safety** (Edmondson, 2019).

In clinical environments, psychological safety is infrastructure. Building it required clear escalation etiquette, transparent communication, and cross-centre briefings that normalised openness over hierarchy.

From Technical Fix to Adaptive Change

Most reforms address the technical and ignore the adaptive (Heifetz, 1994). This pathway demanded both: technical clarity on roles and adaptive courage to confront habit. Leadership meant shifting from authority to authenticity – guiding without command, aligning without coercion, trusting distributed expertise.

Implementation proved that culture follows structure only when structure respects culture.

Translating reform into practice:
The pathway rests on seven design pillars:

1. **Single access point** with standardised documentation.
2. **Tiered escalation** with senior arbitration.
3. **Real-time capacity dashboard** across London centres.
4. **Explicit accountability statements** at every step.
5. **Unified data capture** for audit and learning.

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6. **Human-factors integration** to reduce communication error.
7. **Responsibility continuum** – the patient is always owned by someone.

Each pillar reinforces the others, ensuring structural, behavioural, and data congruence. Feedback loops between referral data, governance reviews, and clinical teams sustain alignment.

Early experience shows the pathway shortens referral chains, reduces duplication, and replaces uncertainty with defined ownership. Evaluation will examine its impact on transfer times and outcomes, but the direction is unmistakable: ambiguity is giving way to reliability.

A Culture of Reliability

Today, "No bed available" is no longer the end of a conversation – it triggers escalation. "Who owns this patient?" now has an answer. The pathway's greatest gain may not be speed but **trust**. When systems articulate responsibility clearly, professionals act decisively. The lesson extends beyond cardiovascular care: outcomes deteriorate whenever ownership diffuses.

Conclusion

The Pan-London Referral, Transfer and Escalation Pathway transformed a coroner's verdict into an operating philosophy. Its message is simple yet systemic: **clarity is care**.

When responsibility is designed into systems rather than left to goodwill, coordination becomes predictable, decisions faster, and accountability collective. In healthcare – as in leadership – structure is compassion made visible. ■

Beyond the Matrix: A Modern Guide to Getting into Cardiothoracic Surgery Training

Ashiq Abdul Khader, NTN, Harefield Hospital, Middlesex
Jeevan Francis, NTN, St Thomas' Hospital, London

In this year's national selection process, 737 applicants competed for 10 training posts in cardiothoracic surgery across the United Kingdom. The numbers alone reveal the intensity of competition, as well as the depth of enthusiasm for this extraordinary speciality. As two of the fortunate few who were successful this year, we wanted to share not a formula for success, but a few reflections from our journeys, including lessons learned, and values that kept us grounded along the way.

1. Build a Coherent Story, Not a Checklist

It is tempting to treat the application process as a tick-box exercise; collect enough audits, publications, presentations, courses, and hope it adds up to a training number. But what often distinguishes one application from another is not quantity, but coherence.

Think of your portfolio as a story rather than a spreadsheet. The best portfolios reflect a theme – perhaps a consistent focus on education, research, or global surgery – that runs through everything you do. A small, well-executed audit that leads to a national presentation, a publication, and a departmental change can be far more valuable than several disconnected projects.

Our advice is to identify what genuinely interests you and pursue it in depth rather than breadth. If you enjoy research, collaborate early and learn statistical analysis. If you are drawn to education, get involved in teaching or curriculum design. If you're passionate about service improvement, follow through with re-audits and implementation.

When your application reflects who you are, rather than who you think the panel wants to see, it becomes more convincing and more enjoyable to build.

2. Mentorship and Collaboration Over Competition

Mentorship often makes the difference between steady growth and losing direction. A good mentor helps you see your potential before you do. They challenge you, encourage you to take opportunities, and remind you that setbacks are part of the process. We were fortunate to find mentors who guided us not only through our applications but through moments of doubt and self-reflection along the way.

Many of our most valuable experiences came through their guidance. For example, by attending electives and taster weeks, we had early exposure to the operating theatre and a better understanding of the realities of surgical practice. They also encouraged us to pursue research in areas that genuinely interested us, which led to projects we later presented at national and international meetings. Ultimately, those experiences helped us see the kind of trainees we hoped to become.

Equally important is the community you build among peers. The competitive nature of selection can make it easy to view others as rivals, but collaboration is far more powerful. Practising mock interviews together and celebrating each other's successes make the process far more rewarding. We learned that collaboration doesn't dilute ambition; it strengthens it. Some of the people we practised interviews with are now our colleagues in training. We both practiced together regularly, challenged and motivated each other, which reflected in interview performances that ultimately afforded not only a training number,

but strong ranks. Helping each other succeed, in many ways, is the first lesson in being part of a surgical team.

3. Setbacks Are Stepping Stones

Almost everyone who applies to this speciality faces rejection at some point – whether that's missing the interview shortlist, an unsuccessful exam attempt, or a research project that doesn't culminate in a publication. Both of us had our share of disappointments before success. In hindsight, those experiences built resilience, patience, and perspective. They forced us to focus on improvement rather than outcome.

After an unsuccessful application, take time to reflect. Seek feedback, identify the gaps, and address them deliberately. Failure, handled well, becomes a quiet teacher. An unsuccessful attempt now is a springboard for an even stronger application for the future, when handled with the correct attitude. When things eventually started to come together, it was the steady effort behind the scenes that had made the difference.

4. Preparing for Interview and Beyond

The interview process is understandably daunting. It tests not only knowledge but also composure, communication, and judgement. Preparation matters; mock interviews with consultants and peers are essential, but avoid trying to memorise answers. Instead, focus on understanding the principles behind the questions: clinical reasoning, ethical awareness, and situational judgement.

When the day comes, nerves are inevitable, and everyone feels them. What makes a difference is preparation. Knowing your portfolio inside out, being well read on current topics in the specialty, and understanding the reasoning behind common clinical and ethical scenarios helps you speak with confidence rather than memorisation. The more familiar you are with your material, the freer your mind is to think clearly when a question takes you by surprise.

For us, what genuinely helped was consistent practice including mock interviews with peers, recording ourselves to refine communication, and reading widely about current developments in cardiothoracic surgery. Those small efforts built confidence and helped the real interview feel more focused and controlled.

Closing Reflections

If there is a single message, we hope readers take away, it's that there is no single path into cardiothoracic surgery. Each journey is unique, shaped by personal circumstances, mentors, timing, and luck.

For those applying in the coming years: begin early, build meaningfully, and don't let temporary setbacks define you. Cardiothoracic surgery remains one of the most demanding yet rewarding fields in Medicine. We are grateful every day for the opportunity to train in this field and for the mentorship that continues to guide and shape us along the way. We hope these reflections encourage others to seek out good mentors, support one another, and keep striving toward the same goal. ■

Don't forget me, Shipmate!

Jules Dussek

When I was working as a thoracic surgeon at Guy's hospital I went on holiday with friends on their boat to France. The theatre staff were horrified at such an adventure and were worried that I would come back with an eye patch, a wooden leg and a parrot on my shoulder. Not wishing to disappoint them I forewent the wooden leg and the eye patch, but brought back a plastic inflatable parrot. That parrot then sat in theatre two on top of the light watching us with a keen eye. When things weren't right we would look at the parrot and wonder what it would think.

I retired and left the parrot behind but a few days later it turned up in my front garden with the message "Don't forget me shipmate!" I was touched, but it wasn't saying don't forget me, the parrot, it said don't forget those days in theatres.

The Bulletin has grown from the ten pages of the first edition to an impressive journal full of information about the current state of the specialty. I'm overwhelmed by it and am versed in the matters particularly concerning surgeons in training but I think back to those days in theatre doing what we were trained and loved to do.

The camaraderie between the nurses, the ODAs, anaesthetists and others is priceless particularly at stressful times, a tear in the pulmonary artery, the awful feeling as a heart coming off by-pass fails to support the circulation and the relief felt by all those in the theatre when it does, but worse, the awful sadness of a patient dying on the table.

I and the parrot will remember those days for ever and they were priceless. It returned to its milieu on our boat for another twenty years accompanying us to the Mediterranean and the inland waterways of Europe

Don't forget the parrot. ■

Minimal Access Cardiac Surgery Masterclass for Future Surgeons – a Training Day to Advance Skills

Monica Mittal, Overseas Trained TAD/NTN, King's College Hospital, London
Mayooran Nithiananthan, King's College Hospital, London

The 4th edition of the **Minimal Access Cardiac Surgery Training Day**, led by **Mr Ishtiaq Ahmed** and his team, once again delivered an outstanding educational experience for trainees interested in the evolving field of **minimally invasive cardiac surgery** (**MICS**). This niche subspecialty continues to gain traction in the UK, with a small but growing number of surgeons offering advanced programmemes in this area. Ensuring that these techniques are passed on to the next generation is vital for the continued evolution of cardiac surgery.

As the specialty advances toward minimally invasive approaches, training is also adapting to meet the demands of these innovative techniques. Cardiothoracic surgery training in the UK faces increasing challenges due to the growing complexity of cases, the implementation of the European Working Time Directive, and the rapid adoption of new technologies – particularly those emphasizing minimally invasive methods.

In 2020, **BISMICS** released a consensus statement on the implementation of a safe minimally invasive mitral programmeme in the UK, highlighting the importance of training future surgeons through high-fidelity virtual reality (VR) simulation models. Evidence across multiple surgical specialties has shown that simulation-based training and VR enhance surgeons' knowledge, support advanced skill acquisition, and improve patient safety.

To prepare future consultants for these evolving practices, an immersive masterclass was developed by **Mr Ahmed** with the support of **BISMICS**, integrating advanced educational modalities such as VR and simulation in both dry- and wet-lab environments using cadaveric models. This intensive one-day course was designed to provide comprehensive exposure to minimally invasive surgical techniques and to bridge the gap between theoretical knowledge and practical application.

The **4th Minimally Invasive Mitral and Aortic Valve Surgery Masterclass** utilized immersive VR technology (VRIMS) to help trainees delineate intraoperative anatomy with remarkable fidelity, offering an educational experience unparalleled in current practice. Through this virtual platform, participants were transported into a realistic operating room environment, enabling them to perform a thoracotomy, expose the mitral valve, and visualize the mitral apparatus in exceptional anatomical detail, as well as observe advanced mitral valve surgery. Comparable modules were delivered for minimally invasive aortic valve procedures, including thoracotomy and endoscopic access, providing high-definition visualization of surgical anatomy and procedural steps.

To further enhance surgical proficiency, the programme transitioned to the **mitral dry-lab**, where trainees practiced using long-shafted instruments, annular suture placement, and mitral valve repair techniques via a right anterior thoracotomy approach. The fidelity of this simulator enabled clear identification of anatomical landmarks and excellent mitral valve exposure. The faculty offered individualized guidance on needle angulation, instrument handling, and tissue manipulation, thereby reinforcing the advanced psychomotor skills required for minimally invasive surgery.

A key component of the masterclass was the **cadaveric training session**. Each trainee, under 1:1 mentorship from expert trainers such as **Mr Ranjit Deshpande**, **Mr Greg Laskawski**, and **Mr Ahmed**, performed independent mitral valve repairs via right anterior thoracotomy and aortic valve replacement using an endoscopic approach. This hands-on experience consolidated the skills acquired in the VR and dry-lab sessions, enabling participants to perform full operative steps with greater precision and confidence. **Sutureless valve implantation techniques** were also introduced, further broadening the trainees' operative repertoire. This direct mentorship provided an invaluable opportunity to refine techniques in a controlled, realistic environment.

It is important to recognise that simulation-based training is not intended to replace direct operative experience. Rather, it functions as a complementary educational tool that facilitates deliberate practice, immediate feedback, and repetition of both routine and complex scenarios in a safe, controlled setting. Simulation therefore accelerates the transition from novice to competent surgeon and fosters readiness for real-world clinical practice.

The ongoing efforts to standardise and integrate simulation-based curricula across surgical specialties reflect a collective commitment to advancing training methodologies. Such initiatives emphasise the specialty's responsibility to ensure technical excellence, patient safety, and consistency in surgical education. The need for structured, simulation-integrated curricula – particularly in minimally invasive mitral valve surgery – is therefore both evident and urgent.

In conclusion, we hope that this masterclass will be incorporated into the **National Training Curriculum**. Its integration into cardiac surgical education represents a pivotal advancement in training methodology – one that aims to improve

operative performance, optimise patient outcomes, and uphold the highest standards of safety. We also recognise that the inclusion of highly enthusiastic trainees and trainers in this innovative niche subspecialty contributes significantly to the NHS vision of developing a better trained, more motivated workforce.

Special thanks are due to **Mr Ishtiaq Ahmed**, **Mr Ranjit Deshpande**, **Mr Greg Laskawski**, **Prof. Jag Dhanda**, and the industry partners – **CorSYM**, **Edwards**, and **CorKnot** – for their generous support and collaboration. The involvement of enthusiastic medical students added further dynamism and ensured the smooth running of the course.

The next edition of this course is scheduled for **February 2026**, and the team is excited to expand the programme to include **surgical atrial fibrillation ablation**.

We strongly recommend this course to all senior cardiac surgical trainees and established mitral surgeons seeking to develop their minimally invasive practice, as it offers a unique opportunity to engage with cutting-edge developments and practical innovations shaping the future of our specialty. ■

Redesigning Mentorship for Modern Surgery: Women at the Table

Farhin Holia, Research Fellow, Royal London Hospital

Women now slightly outnumber men on the UK medical register (GMC 2025). Yet in cardiothoracic surgery, only 13 per cent of consultants are women (RCS England 2024). Representation improves during training but collapses at senior level – evidence that leadership access remains governed by structural habits unfit for a modern, multidisciplinary NHS.

Mentorship has long been the golden thread of surgical growth, yet the apprenticeship model that once sustained it was built for stable teams and fixed hierarchies. Today's system is fluid and distributed. **When opportunity still depends on proximity to one senior figure, progress becomes fragile. In a contemporary health service, no single individual should hold the power to make or break a colleague's career. Leadership must be built into the system, not left to benevolence**.

Ibarra (2019) observes that "successful leaders don't climb ladders; they build bridges." That shift – from positional authority to networked influence – captures what modern surgery now requires.

Research from *Harvard Business Review* shows that professionals who develop broad, cross-disciplinary mentoring networks advance faster and innovate more readily than those relying on a single sponsor (DeLong and Gabarro 2021). **Advocacy is most effective when it circulates widely, not vertically. Moving from heroic mentorship to collective advocacy distributes influence, strengthens resilience, and dismantles gatekeeping**.

The *NHS Staff Survey 2024* found that only 55.9 per cent of staff feel their organisation acts fairly on career progression (NHS England 2024a). That metric is not sentiment but a proxy for performance: teams that perceive fairness report higher engagement and lower sickness absence. **Inclusion is not a moral luxury but an operational determinant of quality and efficiency**.

High-performing surgical units already behave less like pyramids and more like adaptive networks. Authority is fluid, communication transparent, and expertise shared. In several trusts, small "micro-mentorship" circles – short, problem-focused discussions among consultants, trainees, and nurses – accelerate learning and build trust.

Google's *Project Aristotle* identified psychological safety – the confidence to speak up without fear – as the strongest predictor of team effectiveness (Google 2016). Meta-analytic evidence confirms its link with learning behaviour and performance (Frazier et al. 2017). **In surgery, where outcomes depend on rapid information flow, such safety is not soft; it is strategic**.

Allyship extends the same logic. Many effective advocates for women in surgery are male colleagues who understand that inclusion strengthens system performance. True allies act rather than announce; they recognise contributions and name absent voices in decision-making. **As one senior colleague said, "If you are in the room and she isn't, bring her name into the conversation." That simple discipline – amplifying rather than gatekeeping – reshapes culture faster than any policy statement**.

McKinsey & Company (2023) report that organisations with gender-diverse leadership teams outperform their peers. NHS England's *Our NHS People* framework links inclusive leadership to retention (NHS England 2024b). The BMA (2024) estimates that replacing doctors who leave early costs the NHS £1.6–£2.4 billion a year, rising to £5 billion by decade's end. **Retention is the financial expression of fairness. Every clinician who stays because they feel valued strengthens both service and sustainability**.

The goal is not simply to offer women a seat at the table but to redesign the table itself – longer, more flexible, and aligned with the interdisciplinary nature of cardiac care. That redesign begins with examining how leadership roles are publicised, how panels are composed, and how achievement is recognised. **It requires a**

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shift from the language of exception – "the first woman to" – to the language of expectation: of course she did.

The Women in Cardiothoracic Surgery Network within SCTS already exemplifies this model: consultants, trainees, and allied professionals collaborating as equals. It is less a committee than a capability system – proof that culture can be engineered through design, not decree.

High-performance organisations do not treat inclusion as compliance; they operationalise it. Teams grounded in psychological safety outperform peers (Google 2016). Gender-diverse leadership teams generate measurable gains in innovation and results (McKinsey & Company 2023). Within the NHS, even a 15-point rise in perceived fairness could save hundreds of millions by reducing attrition. **High performance is cultural before it is technical: it begins with the freedom to contribute fully and the discipline to ensure every voice is heard**.

The coming decade will redefine surgical leadership through technology, hybrid careers, and evolving workforce models. Mentorship must evolve likewise – from episodic to continuous, from personality-based to system-embedded. **Excellence in surgery has never depended on a single person opening a door; it depends on all of us keeping the corridor lit – for those walking beside us and those yet to arrive.** ■

Finding my Breath: Discovering Thoracic/Cardiothoracic Surgery During my SSC

Mohamed Alzouabi, Medical Student, Leicester Medical School

The first time I stood in theatre watching a patient's lung re-expand after resection, I felt something shift within me. The moment was quiet, precise – yet profoundly powerful. I realised then that thoracic surgery is not just about anatomy or technique; it's about restoring something as fundamental as breath.

That moment marked the beginning of a journey that confirmed my aspiration to pursue a career in cardiothoracic surgery.

A Journey Shaped by Resilience

My path to medicine has never been straightforward. I was born and raised in Syria, where the war changed our lives overnight. My family fled to the UK as refugees, and I arrived aged 15, speaking no English. The transition was overwhelming – every lesson at school felt like deciphering a secret code. But with time, perseverance, and the support of those around me, I found my footing.

Receiving the Poster Presentation Prize at the MedEd Conference 2025, with Professor Bob Norman

Losing my father to lung cancer further strengthened my motivation to study medicine. It gave me a personal connection to respiratory disease and a deep respect for the people who dedicate their lives to treating it.

Despite early academic challenges, I persisted – retaking my GCSEs, achieving two A*s and two As in A-levels, and eventually earning a place at medical school after two years of unsuccessful applications. Each setback reinforced the value of persistence – a lesson that now defines how I approach both surgery and life.

Four Weeks That Changed Everything

At the end of my third year at the University of Leicester, I was fortunate to complete a 4-week Student Selected Component


With SSC Supervisior and Mentor, Mr Edward Caruana (Consultant Thoracic surgeon)

(SSC) in the thoracic surgery department at Glenfield Hospital, Leicester, under the supervision of **Mr Edward Caruana**, Consultant Thoracic Surgeon.

Those four weeks were transformative. In theatre, I observed and scrubbed in for a multitude of cases: from endobronchial work to extensive resections. I observed how the entire team – surgeons, anaesthetists, scrub nurses – communicated seamlessly, every movement deliberate and essential. The teamwork fascinated me; the precision inspired me.

I followed patients throughout their journey – from diagnosis to postoperative recovery. Seeing patients return after surgery, breathing easier and smiling again, brought immense satisfaction.

Equally, witnessing moments when bad news had to be delivered reminded me of the human weight behind every scan and incision. These experiences gave me a deeper understanding of empathy, communication, and the delicate balance between clinical detachment and compassion.

Mentorship and Opportunity

One of the defining aspects of this experience was Mr Caruana's mentorship. He didn't just supervise me – he believed in me. He introduced me to other surgeons and colleagues within the hospital, guided me through research opportunities, and continually encouraged me to push beyond my comfort zone. His trust gave me the confidence to believe that I, too, belonged in this field.

It was through his guidance that I began to see Cardiothoracic surgery not as an unattainable dream, but as a tangible path built on curiosity, discipline, and teamwork. Mentorship, I learned, is the bridge that connects potential to purpose. Since completing my SSC, I have continued to build relationships with the thoracic team and to engage both clinically and in ongoing academic and research projects, deepening my understanding of the specialty and strengthening my desire to pursue a future within it.

Bringing Research to Life

Alongside my clinical exposure, I worked on a research project exploring the impact of training on clinical outcomes after lung volume reduction procedures. What started as a data-driven task soon became a lesson in curiosity and clinical relevance. Research, I realised, is not about assimilating numbers but about asking meaningful questions that improve patient outcomes.

The project was completed successfully and presented at a local **Medical Education Conference**, where it **won first prize in the student poster category**. The abstract was also **accepted for national presentation at the 2025 SCTS National Research Meeting** (**NRM**).

Presenting this work has been both humbling and inspiring. It allowed me to engage with leading clinicians and career academics – and to see firsthand how clinical practice and academic inquiry strengthen one another within thoracic and cardiothoracic surgery.

What the SSC Taught Me

My SSC was more than a placement – it was a turning point. It taught me how complex and rewarding thoracic surgery is, how teamwork and communication underpin every successful operation, and how vital mentorship can be in shaping a young doctor's journey.

It also gave me clarity: this is the field where I want to – and can – belong. A specialty where science meets compassion, and where every case offers both challenge and meaning.

A Message to Future Students

To students exploring their interests in surgery – whether in cardiothoracic or any other field – my advice is simple: be consistent, stay curious, and take initiative early. If your medical school offers Student Selected Components or electives, I strongly encourage you to consider cardiothoracic surgery. It's a specialty that will challenge and inspire you in equal measure, and the earlier you experience it, the more you'll understand its unique blend of technical precision and teamwork.

Try to get involved in research within the specialty – even small projects can teach you valuable skills in critical thinking, collaboration, and communication. Research gives you the chance to contribute to the ongoing development of the field and helps you see how innovation directly impacts patient care.

You don't need to have everything figured out. All you need is the willingness to show up, ask questions, and work hard. The right mentors will see that – and they'll help you find your way, just as mine did for me. Every placement will teach you something – sometimes about surgery, sometimes about yourself – so reflect often and never underestimate the power of persistence.

Acknowledgement

I would like to sincerely thank **Mr Edward Caruana**, **Consultant Thoracic Surgeon**, for his exceptional mentorship, encouragement, and guidance throughout my SSC and beyond. ■

The First Hull Thoracic Symposium

Salman Arif, Cardiothoracic Surgery Medical Practitioner, Castle Hill Hospital, Hull
Adnan Raza, Consultant Thoracic Surgeon, Castle Hill Hospital, Hull
Vailieios Tentzeris, Consultant Thoracic Surgeon, Castle Hill Hospital, Hull
Michael Gooseman, Consultant Thoracic Surgeon, Castle Hill Hospital, Hull
Syed Qadri, Consultant Thoracic Surgeon, Castle Hill Hospital, Hull

The **First Hull Thoracic Symposium** marked a significant milestone for the region's respiratory and thoracic surgical services. The event was organised by the Department of Thoracic Surgery under the leadership of Mr Qadri, the Clinical Lead. It brought together specialists from across the spectrum of thoracic care – including respiratory physicians, thoracic surgeons, anaesthetists, oncologists, radiologists, pathologists, physiotherapists, nurses, surgical care practitioners, and healthcare managers. The aim of this meeting was to share experiences, strengthen collaboration, and chart a unified path for the future of thoracic care in Hull and beyond.

This symposium was sponsored by Irwin Mitchell and the clinicians and healthcare professionals from across the Humber region keenly attended and participated in it. Dr Kate Wood, the Chief Medical Officer was the chief guest. The executive teams of the trusts and executive team of Lung Cancer Alliance also attended the symposium. Abstracts and service reports were presented followed by a question answer session and open discussion whereby the participants shared their success stories along with the struggles that they face every day. The symposium concluded with the distribution of certificates and awards to acknowledge the contribution of members of the wider team.

The symposium opened with a warm welcome from Mr Qadri, Consultant Thoracic Surgeon and Chair of the Organising Committee. He highlighted how thoracic services are evolving in the Humber region with the introduction of the Lung Health Check Programme and advent of perioperative treatment. In his opening remarks, he reflected on the increasing complexity of thoracic disease management and the increasing role of multidisciplinary team in improving patient outcomes.

The vision of the symposium was to establish Hull as a regional centre of excellence in thoracic care, grounded in innovation, research, and patient-centred service.

The scientific programme was opened by Mr Tentzeris, who gave an overview of the advanced emphysema services at Hull. He talked about patient selection for lung volume reduction surgery, bronchoscopic interventions, and multidisciplinary decision-making regarding management in complex cases of emphysema. His presentation underscored the commitment of the team in offering cutting-edge, individualized care for patients with severe COPD.

Mr Gooseman spoke about the experience of robotic thoracic surgical services in Hull, highlighting how the use of robotic technology has promoted precision in surgery, and improved patient outcomes. He emphasised the importance of training and team coordination in successfully integrating robotics into routine practice.

> **"The vision of the symposium was to establish Hull as a regional centre of excellence in thoracic care, grounded in innovation, research, and patient-centred service."**

Next, Mr Barton spoke on palliative radiotherapy for lung cancer patients, reminding the audience that palliation remains an important part of comprehensive cancer care. His talk focused on symptom control, quality of life, and coordination between oncology and palliative care services.

Dr Victoria Brown spoke on the evolving role of perioperative chemoimmunotherapy in the management of lung cancer and presented the results of the Checkmate trial and NICE guidelines, emphasising early multidisciplinary planning to optimise patient pathways.

Building on that, Mr Salman Arif presented the unit's early experience of major lung resection after neoadjuvant treatment. His data was encouraging in regard to postoperative outcomes and provided valuable insights into the technical and clinical challenges of operating on patients who have received preoperative systemic therapy.

A short tea break gave participants a chance to network and share ideas among themselves before the next session resumed.

After the break, Mr Aron Hale then presented findings from the audit on Day 0 mobilisation of thoracic surgical patients, showing how early mobilisation contributes to faster recovery, reduced complications and improved patient satisfaction. His audit was appreciated for its relevance to enhanced recovery programmes.

Professor Jack Kastellick then presented the experience of the Mesothelioma MDT in Hull, describing the multidisciplinary

coordination involved in diagnosing and managing this difficult disease. Following him, Mr Qadri presented the outcomes of mesothelioma surgery in Hull. He demonstrated the unit's commitment to offering surgical options within carefully selected, evidence-based frameworks.

One of the most poignant moments of the morning came from Mr Ian Burrell, a patient who had undergone treatment for mesothelioma, when he shared his personal story. His story of bravery, resilience, and thankfulness put into real perspective the human face behind every clinical discussion. Professor Lind, Trustee of Mesothelioma UK, also addressed the audience, praising Hull's multidisciplinary approach and reiterating their support for regional mesothelioma services.

A legal update was then given by representatives from Irwin Mitchell, giving very useful guidance on medico-legal aspects related to asbestos exposure and compensation pathways for patients.

Lunchtime brought a halt to the sessions, allowing further opportunities for networking and informal discussion among delegates.

In the afternoon, Mrs Bampton discussed the role of the Surgical Care Practitioner within the thoracic surgical team. She discussed how SCPs enhance perioperative care and continuity for patients, improving service delivery and efficiency in a major way.

Next up was Ms Harriett with an update about the CPEX service, giving information on the role of Cardiopulmonary Exercise Testing in preoperative risk assessment and optimisation. Her presentation reinforced how proper functional evaluation helps tailor surgical planning and reduce postoperative complications.

Dr Kanwal Tariq gave an overview of the Lung Health Screening Programme, which has been instrumental in early diagnosis and better survival rates in the region. Her data highlighted how community-based screening initiatives are changing the face of lung cancer.

Later, Mr Qadri returned to share the challenges that the thoracic surgical department faces; workforce pressures as well as theatre and ward capacity. He also outlined the future goals of service expansion and continued quality improvement. This was followed by the Service Manager, Mr Steven Smyth, who talked about the future of the thoracic surgical service. He highlighted ongoing investments in infrastructure, technology, and staff development, underlining the need to sustain momentum in joint working across all specialities.

The day ended with an inspiring address from Dr Kate wood, the Chief Medical Officer, who praised organisers, speakers, and participants for their dedication and innovation.

In recognition of outstanding contributions, research presentations, and service excellence, awards and certificates were given to celebrate the achievements of the day. ■

Launch of initial survey at SCTS Conference, March 2025

The James Lind Alliance Priority Setting Partnership for Chest & Lung Surgery in the UK and Ireland

Helen Shackleford, NAHP, PSP Co-ordinator Birmingham
Babu Naidu, Consultant Thoracic Surgeon, Queen Elizabeth Hospital, Birmingham
Karen Redmond, Consultant Thoracic Surgeon, The Mater Hospital, Dublin

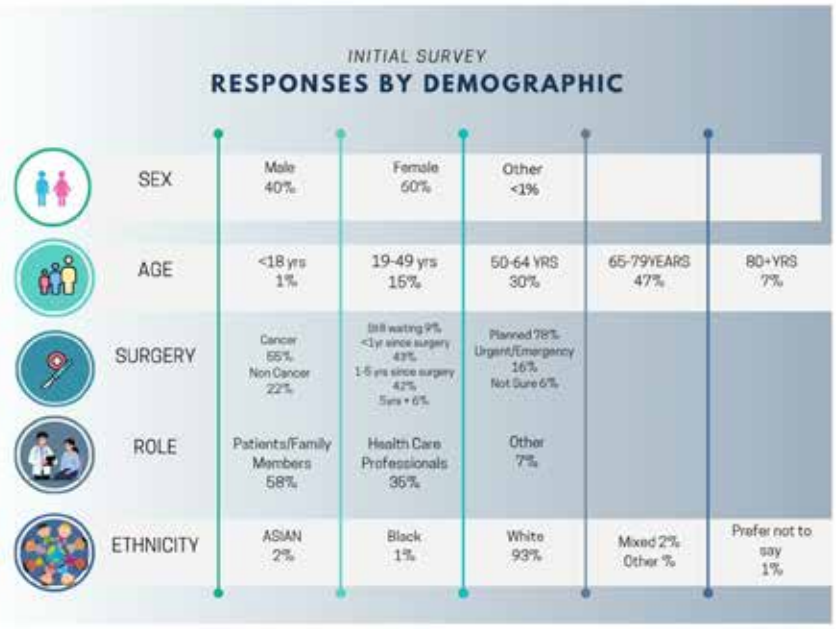
The James Lind Alliance (JLA) Priority Setting Partnership (PSP) for Chest and Lung Surgery in the UK and Ireland was established in February 2025 at the request of the Society for Cardiothoracic Surgery. The James Lind Alliance (JLA), which is funded by the National Institute for Health Research, operates as a non-profit initiative.

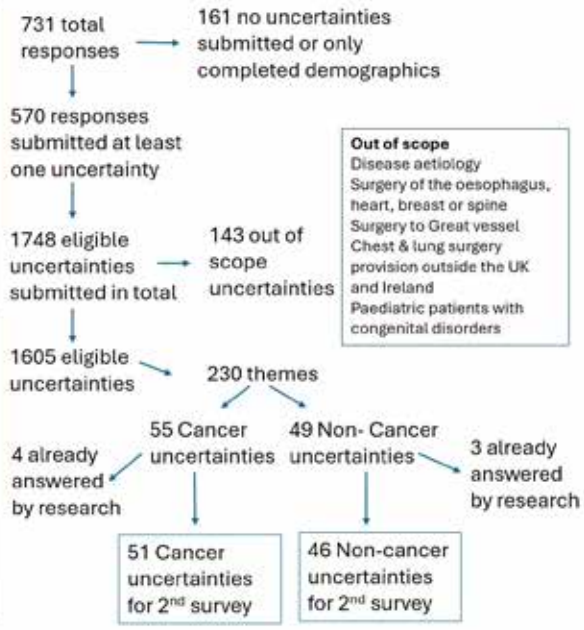
The goal of the PSP is to pinpoint and rank the most important unanswered questions about chest and lung surgical care. By working together, persons with lived experience (PWLE) and healthcare professionals (HCPs) can help direct future research toward the issues that matter most to those directly impacted.

The steering committee for the Chest & Lung Surgery PSP has 39 members, including PWLE and representatives from support organisations like the Roy Castle Lung Cancer Foundation and Pectus Matters. It also includes HCPs from various fields – such as physiotherapists, nurses, an anaesthetist, an oncologist, physicians, surgeons, and a health psychologist.

By utilising a systematic approach that incorporates surveys, workshops, and consensus meetings, the PSP collects diverse viewpoints and ultimately establishes a prioritised list of the top ten research agendas.

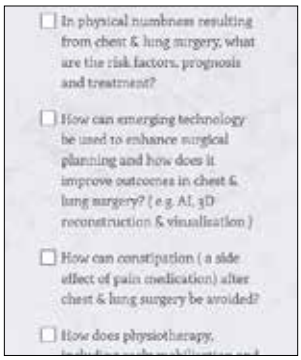
The initial survey launched in March 2025 provided respondents with an opportunity to submit questions they believed remained unanswered by existing research. Given the variation in regional practices and access to surgery, Unit Champions were designated in each thoracic surgical unit throughout the UK and Ireland. These individuals were tasked with ensuring comprehensive representation, by overseeing the distribution of the survey within their





respective units. This approach proved effective, yielding responses from all geographical regions.

Survey demographics were also carefully tracked to maintain balanced representation, and specific strategies were implemented to increase participation among groups with lower response rates. For example, to improve the number of male respondents, the survey was advertised by a well-known football podcaster, and to improve responses from ethnic minorities a video in English & Punjabi was created and aired on various social platforms.


In physical numbness resulting from chest & lung surgery, what are the risk factors, prognosis and treatment?

How can emerging technology be used to enhance surgical planning and how does it improve outcomes in chest & lung surgery? (e.g. AI, 3D reconstruction & visualisation)

How can constipation (a side effect of pain medication) after chest & lung surgery be avoided?

How does physiotherapy,

Survey Responses

An information specialist compiled the survey responses and identified recurring themes. The steering group then collaboratively revised and condensed the submitted questions within these themes into summary questions, with each pair comprising one individual with lived experience and one healthcare professional. These summary questions were subsequently reviewed by the project lead and the remaining members of the steering group.

After identifying the summary questions, the information specialist, working with Associate Surgical Specialty Leads, conducted a literature review. The evidence types used to determine which questions remain unanswered include systematic reviews and clinical guidelines. Questions that had previously been answered were put aside.

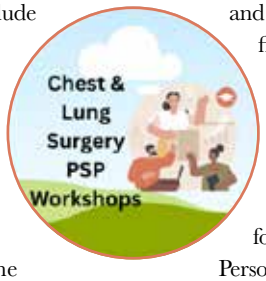
Throughout this process, the steering group engaged in deliberations concerning the potential benefits of separating the PSP process into two distinct streams: one for cancer conditions and another for benign conditions, each yielding its own top ten priorities. While this strategy would necessitate the coordination of two separate workshops, it was anticipated to provide enhanced clarity and focus for each category. Following the identification of the remaining summary questions, it was determined that this approach would be adopted.

Taxi Driver Short https://vimeo.com/1088709939

The second survey, which contains outstanding questions, is now being distributed. This survey presents respondents with a list of over 50 questions compiled and refined from the initial survey, and requests that they select the ten they consider most important.

Responses to this second survey will be carefully tracked, just as they were for the initial survey, to ensure balanced demographic representation. If any areas show low response rates, strategies will be implemented to boost participation.

The results from this second survey will be compiled, and approximately 30 of the most frequently selected questions relating to cancer and benign conditions will advance to the final workshop stage. These workshops are scheduled for Monday, 9th March 2026 (cancer) and Tuesday, 10th March 2026 (benign) at Conference Aston in Birmingham. We are seeking 30 participants for each day; a combination of Persons With Lived Experience (PWLE) and healthcare professionals to review the outstanding questions and determine the top ten priorities for each category. If you are interested in participating or know of people with lived experience who may wish to attend, please contact us for further information.



Thoracicpsp@gmail.com

The two final top ten priorities for chest and lung surgery will be shared at the SCTS conference in Belfast, 15–17 March 2026. ■

Take part in the second survey: **www.surveymonkey.com/r/PLS89J7**

Lung Volume Reduction at the Mater Hospital, Dublin: A Nurse's Perspective on Innovation and Hope

Eimear Norton, NAHP, Mater Misericordiae University Hospital, Dublin

As a nurse working with patients who live with advanced COPD, I see the daily reality behind the statistics – the fear of breathlessness, the frustration of limitation, and the courage it takes to keep going. For many, when maximal medical therapy no longer brings relief, **Lung Volume Reduction** (**LVR**) can offer a new beginning – a chance to breathe easier, move more freely, and reclaim quality of life.

At the **Mater Misericordiae University Hospital**, home to Ireland's **National Cardiothoracic Transplant Unit**, we have developed a national framework for LVR that brings together thoracic surgery, lung transplantation, and a multidisciplinary team of clinicians, nurses, and physiotherapists. The goal is simple but profound: to deliver safe, evidence-based, and compassionate care for people with severe COPD.

A Collaborative, Patient-Centred Approach

Under the leadership of **Professor Karen Redmond**, **Professor Donna Eaton**, and **Mr John Hogan**, our specialist service supports regional and tertiary hospital MDTs, ensuring consistency in LVR assessment and care across Ireland. Every month, a dedicated **LVR multidisciplinary team** (**MDT**) meets at the Mater to discuss complex cases, ensuring that each patient's plan is considered holistically and collaboratively.

Within this framework, **Advanced Nurse Practitioners** (**ANPs**), **Clinical Nurse Specialists** (**CNSs**), and **Advanced Physiotherapists** play a central role. As nurses, we coordinate the patient journey – guiding individuals through testing, providing education, managing comorbidities, and ensuring clear communication across all specialties. Our physiotherapy colleagues focus on rehabilitation and exercise-based recovery, helping patients rebuild strength and confidence. Together, we help transform a complex process into a supported, human experience.

Making Care Easier to Access

Recognising the strain that multiple hospital visits can place on those with severe COPD, we recently introduced a **"one-stop, one-day" assessment model** at the Mater. This allows all required investigations – including CT, perfusion scans, echocardiography, and cardiopulmonary exercise testing – to take place on the same day, followed by a full MDT review.

Since our first LVR procedure in 2017, nearly **800 patients** have been evaluated, with improved access, faster decision-making, and noticeably better patient experience. This model reduces travel stress, shortens waiting times, and allows us to deliver coordinated care that truly meets patients where they are.

Why LVR Matters

LVR, whether surgical or bronchoscopic, works by removing or collapsing the most damaged parts of the lung, allowing healthier tissue to expand and improve breathing efficiency. The benefits go beyond numbers on a chart – we see patients walking further, needing less oxygen, and living again.

International studies continue to support these outcomes, with sustained improvements in exercise capacity and quality of life up to two years post-procedure. Our team's pathways follow the **Irish Thoracic Society's LVR protocol**, ensuring national consistency and safety.

For some, LVR even serves as a **bridge to transplantation**, improving stability while they await donor lungs. For others, it can delay or remove the need for transplant altogether – allowing them to live more independently for longer.

Research, Education, and Collaboration

The Mater team has been proud to lead and contribute to national and international research that shapes the future of LVR care in Ireland. Our work – from the **Delphi consensus on expert LVR opinion** to studies exploring health economics and multidisciplinary team integration – is helping to build a more unified,

evidence-driven framework for COPD management nationwide.

In addition to research, education remains a cornerstone of our mission. A decade after hosting the national *"Initiatives in COPD"* meeting, we recently ran Ireland's first **Allied Health Professional** (**AHP**) **Lung Volume Reduction Study Day** in partnership with **Pulmonx Corporation**, bringing together nurses, physiotherapists, and clinicians from across Ireland. It's now set to become an annual event, supporting shared learning and national collaboration.

Looking Ahead

Our next steps include establishing **Ireland's first National LVR Registry** to track outcomes and improve transparency and developing a **public information portal** for patients and referring clinicians. Ultimately, our vision is for the Mater Hospital to be recognised by the HSE as Ireland's **National Centre for Lung Volume Reduction**, ensuring equitable access to this life-changing therapy.

As a nurse, it's a privilege to walk beside patients on this journey – from the fear of breathlessness to the first confident steps after recovery.

One of the most meaningful moments in my experience working with this cohort of patients occurred during a recent virtual follow-up. The patient, speaking with calm pride in their voice, described how they had just returned from the supermarket – an activity that, for years, had been limited by debilitating breathlessness. What for many is a routine errand had, for them, become a personal milestone and a symbol of regained independence following lung volume reduction.

It was a powerful reminder that the true success of these interventions extends far beyond clinical metrics. The ability to restore dignity, autonomy, and quality of life – to enable patients to once again take part in the ordinary experiences that define daily living – is the ultimate measure of why we do what we do.

"What stays with me most," says Eimear Norton, Clinical Nurse Specialist, *"is seeing patients rediscover confidence in their own bodies – that moment when they take a deep breath and realise they can truly live again."*

Each story reminds us why innovation, teamwork, and compassion matter. At the Mater, we're not just improving lungs – we're helping people find hope, one breath at a time. ■

Inspirational Women in Cardiothoracic Surgery Through the Eyes of a Sixth Form Student

Shukrithi Kumaresan, Medical Student, King Edward VI Camp Hill School for Girls

My interest in cardiothoracic surgery began when I was just six years old. I was lying on my father's chest hearing his heart beating, and with every beat a new question arose in my mind. Why does our heart beat? How does it beat? What does it do? That one moment sparked my interest towards the heart. As I began to learn more about the circulatory and respiratory systems, I was amazed at how the body completes such complex, yet vital tasks every second. However, as I began to discuss my interest in this field with my friends and family, I was greeted with very little encouragement. I was told it is a physically demanding and challenging field, dominated by males. These comments drove me to research women in cardiothoracic surgery. It was only then that I realised how women have shaped the field into what it is today.

Nina Starr Braunwald was the first female to perform open heart surgery. She was a successful cardiothoracic surgeon during a period where less than 10% of the surgical field were female surgeons. Braunwald is a very inspirational figure for many young women as she is evidence that women can indeed be successful and make a change in a field that is dominated by men. Braunwald's accomplishment has paved the way for many females, not only in the cardiothoracic field, but also in the surgical department. This is evident in the growth of female consultant surgeons from 3% in the 1990s to 16.9% in 2024. Although this is still a minority group, it proves that there is a positive global shift in the numbers of female surgeons. She also led the first team to replace a human mitral valve, with an artificial valve that she had designed. To this day, Braunwald's actions continue to motivate and aid women to become cardiothoracic surgeons, through the Nina Starr Braunwald Award. This award supports women in cardiothoracic surgical training or laboratory research programmes by giving them $55,000 for two years, providing women with financial support to aid their journey in becoming surgeons. I have highlighted just one of the many pioneering and motivating female cardiothoracic surgeons.

Cardiothoracic surgery has become more accommodating and supportive of women, through the formation of support groups such as WiCTS (Women in Cardiothoracic Surgery) started by European Association of Cardiothoracic Surgeons (EACTS) from 2021 and the 'Lift as You Climb' mentorship scheme initiated by the Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS) from 2023. The help and guidance provided through mentorship is extremely useful for aspiring surgeons like me. Combined with changing times and attitudes towards working women, the stage is being set for a boom in aspiring talents to follow these pioneers.

To date, SCTS is the only professional organisation to offer free membership for students in the sixth form. This membership enables aspiring cardiothoracic surgeons, like me, to access resources, mentorship and guidance to achieve my goal. ■

SCTS London to Brighton Bike Ride 2025: National Fundraising as a Medical Student

Fatemeh Habibi Nameghi, Medical Student, Norfolk & Norwich University Hospital, Norwich

When I agreed to help with the logistics for the SCTS inaugural fundraising bike ride, I would not have foreseen myself hand-packing dried fruit into kraft bags at 3 A.M on the day of the ride. These snacks would go on to fill the rows of red, yellow, and blue lunch bags on our SCTS welcome stand, perched on the Brighton beachfront. Throughout a windy Sunday in September, they were handed out to our volunteers, film-crew, and thirty-one riders on their arrival from London (a further four could not make it on the day).

The preparations for this event snowballed from a small pilot of 4-5 to 'see how it goes for next year' to the President's now familiar 'secret plan' of smashing the target! To think we went from a standing start a month before when I first agreed to oversee the ride logistics. What started off as a small pilot to give SCTS more public fundraising and visibility, grew into a significant community effort which I had the privilege of fronting. But where an idea takes on a life of its own, challenges and learning promptly follow…

Navigating those problems takes dynamic reactivity, something I managed to demonstrate well, but fundraising doesn't happen in a vacuum, and often, you are navigating people as well as problems. Tilly Mitchell, SCTS Conference Organiser, Business Development and now fundraising organiser, was my compass for this ride. Together, we sailed the currents of customs delays to the arrival of our customised gear and waited with bated breath as a slew of yellow warnings arrived from the Met Office, forecasting thunderstorms.

Mr Ishtiaq Ahmed, who is a Consultant Cardiac Surgeon in Brighton and part of the BISMICS steering committee, was a huge help. His Brighton team was paramount in providing the local expertise which helped to ensure smooth sailing at our SCTS welcome stand on the day.

There are many other unforgettable individuals who joined our team in our moments of need and for them we are truly grateful. The President had a big birthday in the week of the ride, and the cutlery for his birthday cheesecake was provided to us free of charge by one of the beachfront diners. The kettles we used to serve hot drinks were borrowed from kitchen staff at the hotel where I was staying. The no-vehicle policy on the beachfront meant that our equipment needed to be transported to our welcome stand on foot, and I would again like to thank the strangers who made the trek to the top of the hill to help us with our equipment just because I asked.

Little impromptu fundraising teams seemed to spring up just as I needed them. The staff at the store where we bought the lunches gave us a 25% discount and free chocolates when they heard that the meal deals we were buying were for charity. They were probably a big reason why at the end of the event, I was still within our catering budget (much to Tilly's delight).

While it is our riders who have raised over £40,000 to make heart, chest and lung surgery better, in these moments where help arrived just as we needed it, our team seemed infinite.

Near the end of the day, the queues of riders waiting for buses home were coloured with flashes of silver. I had handed out our extra foil blankets to anyone scurrying without a coat in the now heavy rain, including those who were not members of the SCTS team.

I wrote this piece to provide a first-hand glimpse of what it was like to organise SCTS' first bike ride fundraising event. Fundraising is a great deal of effort! Throughout the six weeks of planning and executing, I designed and revised flyers and flags, created social media posts, and sourced food, accommodation, equipment and people. Clear communication was my steadfast companion, whether with the rest of the team, vendors or the event organisers. While not everyone who embarks on a fundraising initiative will have someone like Tilly to answer their questions (without complaint), my advice would be to remain unafraid of asking. Know your own limitations, ask for help when you need it, and accept it when it is offered.

Teamwork has many forms, as it did through all of the people who made this bike ride a success: patients, surgeons, doctors, students, allied health professionals, industry, and the people of Brighton. If you want to be one of those people next year for the 2026 SCTS London-to Brighton ride, please reach out to us, and let's continue to make heart, chest and lung surgery better. ■

The SCTS London to Brighton Bike Ride 2025 was sponsored by **CMR Surgical**.

A Student's Perspective from Royal Papworth Hospital: A Full-Circle Moment

Timon Girgis, Medical Student, St. George's University Medical School

I had the privilege of undertaking a four-week elective at Royal Papworth Hospital, one of the world's leading centres for cardiothoracic surgery. Papworth's reputation for innovation, complex surgery, and multidisciplinary excellence made it the ideal environment to observe some of the most skilled surgical teams in the specialty.

Before studying medicine, I worked for several years as an Operating Department Practitioner (ODP) and later as a Surgical First Assistant (SFA). My route into medicine was unconventional, and joining later in life came with challenges, but my years in theatre gave me something invaluable. I may not have been the most academic student, but I entered medical school with experience and perspective that many of my peers did not yet have, and a mindset shaped by teamwork, responsibility, and resilience. Now I find myself at a centre of excellence in the heart of Cambridge, among academics, researchers, and surgeons who push the boundaries of medicine.

I remember clearly, as a student ODP, watching the retrieval team from Papworth visit my hospital and falling in love with cardiothoracic surgery. Since then, I had followed every documentary and article about their pioneering work, admiring the surgeons and teams from a distance who challenged limits and changed lives. Papworth always felt like another world. To now find myself here, standing alongside the very people I once looked up to, feels surreal.

Over those four weeks, I scrubbed in for a wide range of cases – from coronary artery bypass grafting and pulmonary thromboendarterectomy to a lung transplant. Feeling a beating heart beneath my hands and witnessing life restored with each breath was nothing short of extraordinary. Some procedures seemed to defy the laws of the human body, a humbling reminder of how far surgical science has come.

One moment I will never forget was performing my first thoracotomy during a complex trauma case under Mr Aman Coonar's guidance. It was just one step in a long operation, yet for me, it marked a milestone in my surgical training and reaffirmed my commitment to pursuing a career in surgery.

Beyond the theatre, I joined the transplant retrieval team, witnessing both donation after circulatory death (DCD) and donation after brain death (DBD) retrievals. I even had the opportunity to perform a bronchoscopy under supervision to assess donor lungs before surgery. These experiences brought the scale and significance of transplantation into focus, revealing the science, logistics, and humanity behind every decision.

Participating in ward rounds and multidisciplinary meetings offered further insight into the continuity of care that defines Papworth's approach. Watching surgeons, anaesthetists, perfusionists, physiotherapists, and nursing staff collaborate seamlessly highlighted the essential role of communication and teamwork in achieving optimal patient outcomes.

A particular highlight was attending the Royal Society of Medicine's "Future of Cardiothoracic Surgery and Anaesthesia" meeting. Listening to discussions on robotics, artificial intelligence, and next-generation surgical techniques was both inspiring and energising. It offered a glimpse into a specialty that never stands still, constantly pushing boundaries and redefining what is possible.

Reflecting on my time at Royal Papworth, I feel both privileged and inspired. The elective strengthened my technical and clinical skills, deepened my understanding of complex cardiothoracic disease, and gave me a profound appreciation for the dedication required at the forefront of this specialty. Above all, it reminded me why I chose medicine and why I am drawn so strongly to surgery.

This experience was more than a placement; it was a full-circle moment that connected the person I was to the clinician I hope to become. From watching Papworth teams on a documentary as a student ODP to standing beside them in theatre, every step reinforced the values of teamwork, resilience, and commitment that define not only great surgeons but the practice of medicine itself.

All of this would not have been possible without being awarded the RCSEd / Vascutek Cardiothoracic Surgery Placements for Undergraduates grant, for which I am eternally grateful. ■

Ionescu Trust Appointed Doctors Small Travel Awards 2023: Visit to Yale Aortic Institute

Riccardo Abbasciano, NIHR Senior Fellow, Hammersmith Hospital, Imperial College Healthcare NHS Trust – University of Leicester

My career in cardiac surgery has increasingly focused on thoracic aortic diseases, from both a surgical and scientific perspective. This interest naturally led me to the extensive work of Professor John Elefteriades, widely recognised as a leading aortic surgeon whose contributions are the foundation of much of our current understanding and practice in the field of aortic disease. While I had previously collaborated with Professor Elefteriades on several research projects, the Ionescu Fellowship provided me with the opportunity to visit his Aortic Institute at Yale University, from September to October 2023.

A special note of appreciation goes to Mrs Carol Calini, whose meticulous coordination was instrumental to the success of my visit to Yale. Her efforts ensured that every aspect of the fellowship was optimised, allowing me to gain maximum benefit from this exceptional experience.

Upon arriving in New Haven, I was immediately struck by the exceptional quality and breadth of the research in the Aortic Institute. Professor Elefteriades' group conducts diverse scientific investigations into the aorta, ranging from innovative animal models and translational studies to the exploration of novel technologies for analysing the extensive clinical data he has meticulously collected throughout his remarkable surgical career. Of particular resonance to me were the numerous projects exploring the link between genetics and aortic surgery, a field in which Professor Elefteriades is a pioneer, and one that profoundly interests me. Beyond the research, I valued the exposure to his clinical practice. I participated in the review of complex cases referred from around the world, and the clinical reasoning insights I gained during those days continue to inform my daily decisions.

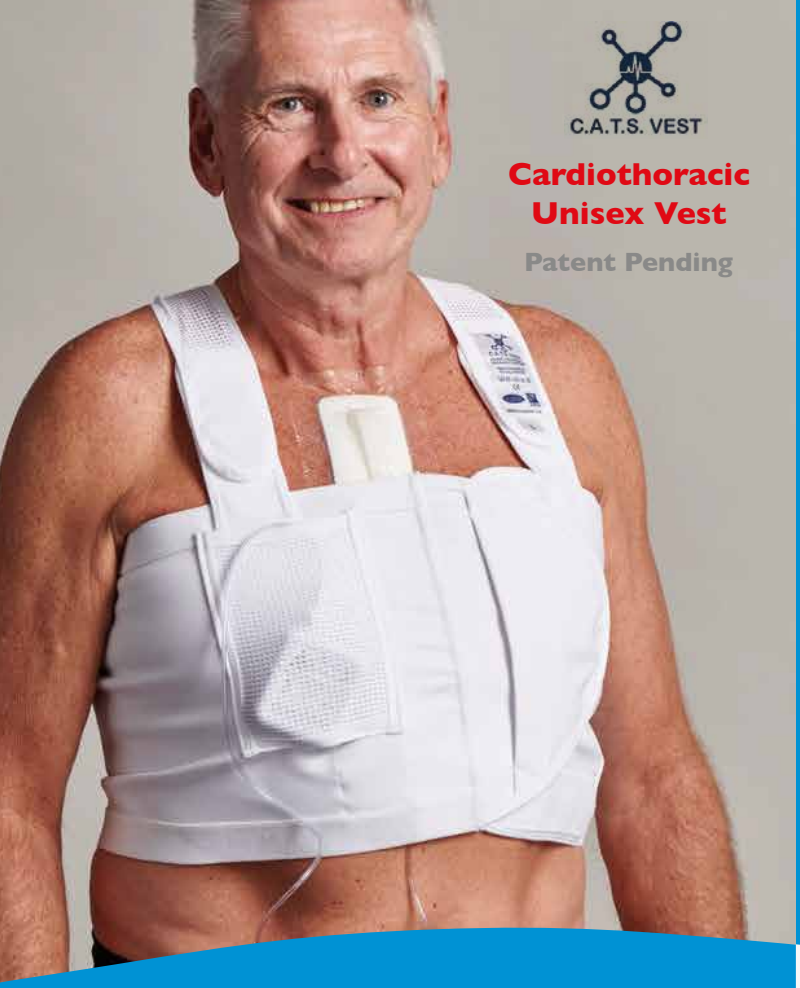
During my weeks at Yale, I was fully immersed in a dynamic clinical and research environment. The entire team, including Professor Elefteriades himself, Dr Zafar, Dr Ziganshin, and every member of his research group, extended an incredibly warm and genuine welcome. Professor Elefteriades is renowned not only for his profound contributions to cardiac surgery and aortic disease management but also for epitomising the figure of surgeon-scientist in the contemporary cardiac surgery specialty. Throughout my fellowship, he was consistently welcoming, approachable, and deeply supportive. His willingness to offer expert feedback and guidance, both during the fellowship and in subsequent conferences and research meetings where I had the pleasure of reconnecting with him, remains a significant source of encouragement and inspiration.

The Yale New Haven Health Hospital

My talk in the plenary session of the AATS Aortic Symposium 2024

This experience proved transformative for my development as an academic cardiac surgeon. The insights I gained not only broadened my understanding of aortic research but also directly influenced and refined my current research directions. This engagement was a significant factor in my contribution to the successful development of the DECIDE TAD NIHR Programme, in which I am currently involved. A particularly tangible outcome of the fellowship was the opportunity to deliver an oral presentation in the plenary session of the prestigious AATS Aortic Symposium in New York, in April 2024. It was a proud moment to present our work to a distinguished audience of peers and experts, especially following Professor Elefteriades' opening lecture – a convergence of shared research focus and a touch of serendipity.

The Ionescu Fellowship scheme is a truly commendable program, offering unique opportunities for emerging cardiothoracic surgeons to visit and learn from established, world-leading international centres. I am deeply grateful to the Society of Cardiothoracic Surgery in Great Britain and Ireland (SCTS) for this exceptional opportunity. Their support remains invaluable in fostering and advancing both my academic and surgical development. ■



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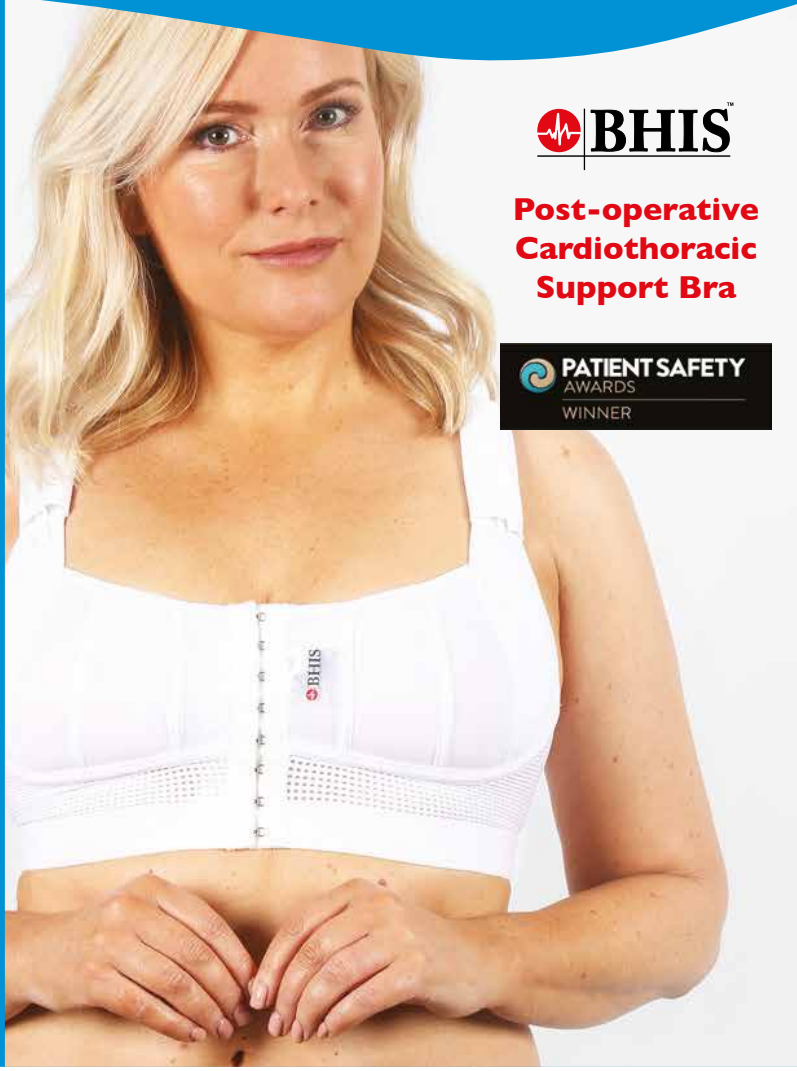

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SCTS–Ionescu Travelling Fellowship Report: Surgical Repair for Ebstein's Anomaly — a Hope for Complex Tricuspid Valve Malformation from Neonates to Adults

Ed Peng, Consultant Cardiac & Congenital Surgeon, Royal Hospital for Children Glasgow

The SCTS Education Committee kindly granted me approval to visit the Children's Hospital of Pittsburgh (CHP) as part of the SCTS-Ionescu Travelling Fellowship in October 2024. This provided me with an invaluable opportunity to meet Dr Jose and Dr Luciana da Silva, who led the Da Silva Ebstein's Centre in Pittsburgh. Dr Jose da Silva pioneered the first Cone operation in November 1993, and since then, the concept and technique have spread worldwide, transforming the lives of many patients born with this complex valve malformation. As the name implies, the surgery creates a fully circumferential valve tissue – i.e. 360 degrees – to form a competent and durable tricuspid valve.

On my first day at CHP, I was personally greeted by Dr Jose da Silva. He embodies not only surgical elegance and excellence, but also humility and grace – qualities equally exemplified by Dr Luciana da Silva. Dr Jose da Silva then introduced me to the patient and his family before heading to the operating room. The family had travelled from Europe to be operated on by Dr Jose da Silva himself. I spent time in the operating room observing both Dr Jose and Dr Luciana da Silva working seamlessly to transform a classic Ebstein's malformation into a new and perfectly functioning anatomical tricuspid valve.

Outside the operating room, I engaged in in-depth discussions about surgical techniques with both Dr Jose and Dr Luciana da Silva. The importance of adequate delamination and mobilization of leaflet tissue was emphasized to create a fully circumferential valve, i.e. the "Cone." In 2019, Dr Jose da Silva described the first takedown of the Starnes procedure and conversion to Cone repair. More recently, he pioneered the takedown of a failing Fontan circulation in a child who was unfavourable for transplant and converted this to a one-and-a-half ventricular circulation via a Cone repair. This procedure transformed a sick child with a failing Fontan, followed by a good recovery and discharge home. While valve repair conversion to replacement may be familiar to many, the reverse – conversion of valve replacement to valve repair using the Cone technique – has also been successfully described by Dr da Silvas.

With Dr Jose and Luciana da Silva outside UPMC Children's Hospital of Pittsburgh

Neonatal presentation of Ebstein's anomaly represents the most extreme form of the disease. Such critically ill neonates are often deemed inoperable. Dr Luciana da Silva recently co-led the development of expert guidelines on the management approach for neonatal Ebstein's. With the correct strategies, severely ill neonates can be palliated before undergoing more definitive repair. Although technically possible in neonates, the delicate valve tissues may be better addressed at a later stage to minimize the risk of dehiscence and improve the longevity of valve repair. The Starnes procedure creates a univentricular circulation, which decompresses the right heart and relieves any left ventricular compression, leading to a better cardiac output. The strategy provides a bridge for these extremely sick neonates, allowing for more definitive and durable valve repair at a later stage. Another surgical alternative of symptomatic neonatal Ebstein's malformation is the monocusp repair, as described by Knott-Craig and others (Hsuang et al.).

Besides observing live surgery, I had the opportunity to review recorded surgical videos and discuss the approach step-by-step. We discussed about mobilizing the septal leaflet deeper towards the apex and recreating right ventricular trabeculations. Cone technique has proven itself as a reliable and reproducible technique which leads to subsequent right ventricular remodelling. Another important aspect of care which I observed at the Da Silva Ebstein's Centre is their early extubation strategy in operating theatre post repair.

In Scotland, Prof. MH Danton and I began incorporating Cone surgery into our program, with invaluable support from our excellent surgical colleague at Freeman Hospital Newcastle, Mr M Nassar. I was keen to optimize our experience and exposure further by visiting Dr Jose da Silva – the very surgeon who devised this ingenious operation – to learn his approach to managing the wide spectrum of Ebstein's anomaly. This trip was highly worthwhile, and I greatly enjoyed both the experience and the friendships built during the visit.

Acknowledgement

I am deeply grateful to the Society for Cardiothoracic Surgery (SCTS) and the late Mr M. Ionescu for their generosity in awarding me a scholarship to visit both Stanford University and the University of Pittsburgh. This invaluable opportunity will undoubtedly enhance our programme back in Scotland. ■

SCTS–Ionescu Travelling Fellowship Report: Peripheral Pulmonary Artery Reconstruction – the Last Hurdle in Reconstructive Surgery for Congenital Heart Disease? Lessons from Stanford University

Ed Peng, Consultant Cardiac & Congenital Surgeon, Royal Hospital for Children Glasgow

In June 2023, the Scottish Paediatric Cardiac Services theatre group had the opportunity to visit the Pulmonary Artery Reconstruction (PAR) Programme at Stanford University. The end spectrum of congenital pulmonary artery disease is extremely complex and may involve pulmonary atresia with multiple major aorto-pulmonary collaterals (MAPCAs) requiring unifocalisation, or patients without pulmonary atresia but presenting with multiple severe peripheral pulmonary arterial stenoses. This advanced disease invariably involves distal stenoses at multiple locations that are often considered surgically inaccessible. Without treatment, long-term outcomes for patients with right ventricular hypertension are generally poor.

At Stanford University, Professor Frank L. Hanley pioneered techniques for single-stage midline bilateral unifocalisation and complete repair of pulmonary atresia with Tetralogy of Fallot-VSD in the early 1990s. Dr Hanley later developed novel approaches to repair peripheral pulmonary arterial stenoses in Williams syndrome, Alagille syndrome, and other elastin arteriopathies. Since then, Stanford has evolved into a quaternary referral centre with its structured Pulmonary Artery Reconstruction (PAR) Programme dedicated to the surgical treatment of end-stage pulmonary artery disease.

The visiting Scottish team comprised a surgeon (Mr E. Peng), two anaesthetists (Dr A. King and Dr S. Leone), and a perfusionist (Mr D. Walker). We had in-depth discussions with the Stanford team to learn their perioperative management strategies. Stanford has developed a unique

The team outside Lucile Packard Children's Hospital

protocol to optimise post-bypass haemostasis, which includes the use of FEIBA. Their cardiopulmonary bypass protocol is also refined to optimise organ perfusion and protection, which is essential given the long cardiopulmonary bypass times required to achieve comprehensive pulmonary artery reconstruction. We also had the opportunity to use a simulated bypass machine to set up a pulmonary artery flow study, facilitating intraoperative assessment of repair completeness. The CVICU is well equipped, with ECMO support readily available if needed postoperatively following PAR. The ENT service is also vital, performing multiple bronchoscopies and suction washouts in the ICU postoperatively.


Team photo with Dr (Professor) Hanley (second from the right) in operating room

From a surgical perspective, our primary goal was to learn the technique developed by Dr Hanley to reconstruct peripheral pulmonary arteries beyond the lung hilum. In the operating room, meticulous dissections were carefully performed to expose peripheral pulmonary arteries beyond the segmental branches, achieving control at the subsegmental level. The surgical techniques involved unique arterioplasties to address multiple ostial lesions in these small branches and reconstruction of pulmonary artery branches to reach the segmental level using pulmonary homograft patches exclusively.

For over 25 years, Dr Hanley has elegantly demonstrated that these peripheral vessels can be surgically reached to permit durable reconstruction. These surgical approaches offer a viable option to address extreme forms of pulmonary artery disease and to achieve optimal right heart pressures – a key determinant of long-term outcome. In the early 1980s, Bill Norwood devised the operative approach to treat hypoplastic left heart syndrome, and in the early 1990s, Jose da Silva developed the Cone repair for Ebstein's anomaly. Peripheral pulmonary artery reconstruction may represent the last hurdle in congenital heart surgery, and we are all greatly indebted to Professor Frank L. Hanley for pioneering this novel approach that boldly reaches deep into the lungs – into areas previously uncharted by others.

Complex PAR therefore offers hope to patients with severe peripheral pulmonary artery disease that has largely been deemed inoperable. It provides potentially transformative surgery that can change the long-term outlook of this disease.

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Acknowledgements

First and foremost, we owe our learning to Dr (Prof) Frank Hanley and his outstanding surgical faculty: Dr Michael Ma, Dr Elisabeth Martin, Dr (Prof.) Richard Mainwaring, and Dr Arvind Bishnoi. I made two trips (June 2023 and October 2024) to join Dr Hanley, Dr Ma, and Dr Martin in the operating rooms. Dr Richard Mainwaring further visited Glasgow to operate jointly with us for a young patient.

We are also extremely grateful to the following Stanford faculty who generously shared their knowledge and experience: Dr Manchula Navaratnam (Cardiac Anaesthesia), Dr Ritu Asija (Cardiology/CVICU), Dr Sushma Reddy (Cardiology/CVICU), Dr Justin Sleasman (Perfusionist), Dr Greg Adamson (Interventional Cardiology), and Dr Catherine Dietrich (Anaesthesia). We are also indebted to Ms Leslie Nguyen and Stacey Kramer (admin team) who facilitated our trip.

I am grateful to my team (Adele, Stefania, and David), who invested their time and interest to be part of the trip and to care for these patients. I am also grateful to Prof Mark H. Danton, my senior surgical colleague at RHC Glasgow, with whom I operate jointly on the most complex patients. Lastly, I thank our clinical director, Dr Mark Davidson, whose vision and commitment support the ongoing development of our congenital heart surgical programme. ■

What I Learnt from a Lung Transplant Fellowship in Toronto

Jennifer Whiteley, NTN, Golden Jubilee National Hospital, Glasgow

Having trained in cardiothoracic surgery, I found myself aware of the gap in provision of lung transplantation within Scotland. With interest, but no prior experience in the field, I sought exposure to a centre that could provide both technical training but also insight into how a high-volume lung transplant programme is organised and delivered.

Toronto General Hospital has an international reputation for thoracic surgical followships, and is home to the world's largest lung transplant programme. I was fortunate to secure support from the Ionsecu Fellowship, whose funding made this transformative year possible.

Why Toronto?

Toronto General Hospital is widely acknowledged as the birthplace of modern lung transplantation. The world's first successful single lung transplant was performed here in 1983, followed by the first double lung transplant in 1986. Volumes now regularly exceed 200 procedures annually, making it the largest programme worldwide. This environment offered the dual attraction of rich operative exposure and immersion in a culture of innovation.

I was particularly interested in three themes:

1. Technical mastery of the transplant procedure itself, including retrieval and the use of ECMO.
2. Exposure to innovations aimed at expanding the donor pool.
3. Lessons from a different healthcare system that might inform the feasibility of developing a lung transplant service in Scotland.

Canadian versus UK Health Systems

Both Canada and the UK operate publicly funded health systems, but there are key differences. In Canada, patients hold provincial health insurance, and each component of care – surgical, anaesthetic, intensivist – is billed separately to the government. Physicians are paid per procedure or ward round, creating a subtle financial motivation that drives efficiency and innovation.

In contrast, the NHS model is salaried and centrally funded. While this avoids financial incentives potentially distorting care, it can limit throughput and responsiveness to demand. Experiencing the Canadian model firsthand highlighted how structural differences shape clinical practice and organisational culture.

Technical Training and Surgical Experience

The Toronto Implant Technique

The standard operation was a bilateral sequential lung transplant via a clamshell incision, performed on central veno-arterial ECMO. Over 10 months, I was able to implant in excess of 40 lungs.

Retrievals

Toronto uses lung-only retrieval teams, separate from cardiac teams, and employs a well-defined "Toronto Technique." Donors were both neurologically determined death (NDD) and donation after circulatory death (DCD). After 10–15 retrievals fellows are "signed off" for independent retrievals, and the variety of settings – from small community hospitals to centres with limited equipment or different languages – tested adaptability as much as technical skill.

ECMO

The fellowship combined lung transplantation with ECMO training.

I completed more than 20 V-V ECMO cannulations for indications ranging from primary lung failure to intra-thoracic surgery support (e.g. major airway resections, post-resection ARDS). This reinforced the tight relationship between ECMO and advanced thoracic practice.

Innovations in Donor Utilization

Ex-Vivo Lung Perfusion (EVLP)
Toronto pioneered ex-vivo lung perfusion, which maintains lungs outside the body and allows functional assessment and even therapeutic intervention. This innovation has dramatically increased donor organ utilisation, allowing acceptance of lungs previously declined, including those from donors with a history of smoking or substance misuse. Ongoing research is even exploring transplantation across ABO blood groups.

The 10-Degree Fridge
Conventional practice preserves lungs at −4°C, but Toronto has demonstrated that storage at 10°C preserves mitochondrial integrity and allows safe preservation beyond 24 hours. This enables daytime transplantation rather than overnight surgery, with no increase in primary graft dysfunction. The implications for surgical scheduling and patient safety are important.

Lessons for the UK

In 2021, Canada performed 352 lung transplants for a population of 43 million, while the UK managed only 105 for 67 million. Strikingly, the UK donor pool is actually larger, but lungs are underutilised due to conservative acceptance criteria and logistical limitations.

Several strategies from Toronto could translate well to the UK:

- Wider use of EVLP for marginal organs.
- Acceptance of lungs from donors with substance use histories.
- The 10°C preservation strategy to reduce unsociable hours and protect elective activity.

Personal Reflections

Beyond the technical knowledge, the fellowship reshaped how I think about surgery. Three insights stand out:

1. **Adaptability is as important as skill**. Retrievals in resource-limited hospitals taught me to improvise, problem-solve, and focus on core principles rather than ideal conditions.

2. **Innovation requires bravery**. Whether it is EVLP, the 10°C fridge, or ABO-incompatible transplantation, progress demands a willingness to challenge orthodoxy and rigorously evaluate new ideas.

3. **Systems matter**. The Canadian model, for all its differences, underscored how structure and incentives shape clinical output. Translating best practice requires attention to organisation, not just technique.

Conclusion

The Toronto fellowship has been transformative, equipping me with both technical expertise and a broader vision for what lung transplantation could become in the UK. As Scotland contemplates the feasibility of establishing its own programme, these lessons feel especially timely.

My time in Toronto also gave me confidence in "big thoracic surgery." Managing technically demanding lung transplants and complex complications provided a solid foundation for becoming a consultant. When combined with UK-based training in robotics, this has directly translated into my current consultant practice, where I have been able to perform sleeve resections and pulmonary artery vasculoplasties robotically. This blending of experiences – high-volume transplant surgery abroad and robotic training at home – has shaped the way I now approach advanced thoracic procedures.

I am deeply grateful to the **Ionsecu Fellowship** for funding this opportunity. Without their support, I could not have accessed such an extraordinary training environment. The experience has left me more convinced than ever that Scotland can – and should – build capacity for lung transplantation, ensuring equitable access for its patients and contributing to the wider advancement of cardiothoracic surgery. ■

Robotic Thoracic Fellowship – The Barts Experience

Tom Combellack, Consultant Thoracic Surgeon, University Hospital of Wales

I had the good fortune to undertake a fellowship in Barts under the supervision of Mr Stamenkovic who is Director of Robotic Surgery and founder European proctor for Intuitive – the company that makes the Da Vinci robot. There is another robotic fellowship opportunity in Guys under the supervision of Mr Routledge.

The Barts robotic programme is unique because it has the most advanced Da Vinci – 4th generation Xi. It is a dedicated thoracic robot with access five days per week for use by all five consultant surgeons including two European proctors, effectively delivering a standardised training experience. In addition, there is a large volume of segmentectomies with full use of robotic adjuncts such as ICG (indocyanine green), exposure to innovative procedures and ideas and involvement in high quality research.

My fellowship was for three months prior to gaining a substantive consultant post in Cardiff but the fellowship usually lasts for 6-12 months. My typical week involved one clinic/MDT a day, two days in theatre and 1 in 6 non-resident on call with relatively light intensity.

Prior to my arrival I completed the Da Vinci online learning modules. Once at Barts I dedicated myself to the simulation training package that comes with the robot. I completed these modules within my first week. The first two weeks I watched on the second console, immersed in the operation, learning the set up and tips and tricks for thoracic robotic operating. In my third week I was signed off on Da Vinci in-service and emergency undock training by one of the Intuitive representatives and performed my first case the same week.

Within three months, I had performed 23 independent cases supported both by Mr Stamenkovic and my registrar colleagues on a range of lung resections including advanced

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segmentectomies and mediastinal procedures. I felt incredibly well supported throughout my learning curve especially with such a slick theatre team. Personal highlights include a robotic lung and chest wall resection and a hybrid robotic procedure with cone beam CT fiducial insertion and localisation.

The whole thoracic team was very welcoming and I was invited to learn in other theatres too. For example, I performed robot procedures with Ms Wilson (European proctor), an extended pleurectomy decortication with Mr Waller and navigational bronchoscopy with Mr Lau. The robotic experience alone was fantastic but the opportunity to see and perform some of the other most innovative and advanced techniques has taken my development to a whole new level. My only regret is that I wish I could have stayed longer!

I think the Barts Robotic Fellowship is a phenomenal opportunity, especially as a post FRCS finishing school. Not only will it be stimulating and broaden your professional network with some of the highest profile surgeons in the country, but it will also put you in a very strong position for any consultant post. I cannot rate it highly enough. ■

Fellowship in Minimally Invasive Mitral Surgery at Maastricht UMC+

Umair Imran Hamid, Consultant Cardiac Surgeon, Nottingham City Hospital

I y interest in minimally invasive mitral surgery was sparked during a mitral valve workshop early in my training. The concept of delivering complex repairs through smaller incisions, with faster recovery and less trauma, resonated deeply. I reached out to Dr Peyman Sardari Nia in Maastricht, a leading advocate of mini-mitral surgery and simulation-based training. His commitment to shortening the learning curve through structured models aligned perfectly with my goals.

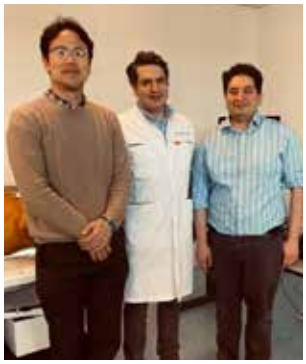
From November 2021 to March 2022, I undertook a focused fellowship at Maastricht UMC+, immersing myself in a high-volume, detail-oriented unit. The experience was transformative – reshaping my operative thinking and confirming that minimally invasive strategies, when paired with rigorous planning and multidisciplinary collaboration, can deliver reproducible, patient-centred outcomes.

Objectives and Expectations

My aim was to convert advanced theoretical knowledge into a repeatable operative technique. I focused on refining tissue handling, annuloplasty strategies, and subvalvular repair methods across a spectrum of pathology – degenerative, functional, and reoperative. I anticipated intensive hands-on exposure, structured decision-making frameworks for access and repair, and perioperative protocols designed to reduce complications and length of stay.

Hands-On Experience and Surgical Exposure

I assisted in two to three minimally invasive mitral cases per week, gaining comprehensive exposure across the entire workflow. Access to the mitral simulation model was invaluable – it accelerated my technical development and allowed me to rehearse core steps in a controlled environment. I learned case setup, instrument selection, port placement, and patient positioning, with particular attention to table angulation for optimal exposure. Repeated involvement consolidated my skills in annuloplasty suturing, subvalvular techniques, and the non-technical elements – communication, theatre choreography, and anticipation – that underpin successful programmes. Participation in MDT meetings sharpened my judgement on case selection and suitability for minimally invasive access.



Mentorship and Team Integration

Dr Sardari Nia's mentorship was both rigorous and generous. He combined academic precision with humility, fostering a collaborative environment where evidence-based decision-making was the norm. His teaching balanced technical demonstration with critical discussion of outcomes and technique. The broader team – nurses, anaesthetists, perfusionists, and ICU staff – modelled a predictable perioperative rhythm through clear roles and consistent communication. Structured briefings and debriefs provided rapid, constructive feedback that accelerated my learning curve and reinforced the importance of team-based excellence.

Learning Beyond the Operating Room

Beyond the theatre, I collaborated on academic articles focused on endoscopic mitral surgery. I also served as faculty for a tele-simulation course for endoscopic mitral surgery, delivering remote instruction and real-time feedback. These experiences reinforced the value of simulation and tele-supported training in accelerating skill acquisition, standardising technique, and expanding access to mentorship.

Reflections and Future Directions

This fellowship solidified my belief that minimally invasive mitral surgery is a driven discipline. It refined my approach to complex repairs and highlighted how small technical adjustments yield measurable benefits. Simulation training is essential to shortening learning curves and ensuring reproducibility. My goal is to integrate the skills and experience I've gained to establish a sustainable, patient-centred, minimally invasive mitral valve programme within my institution.

I remain immensely grateful to the Society for Cardiothoracic Surgery in Great Britain and Ireland (SCTS) for their generous support in making this fellowship possible, and for their continued commitment to advancing education and excellence in our field. ■

Fit to Skill: Protecting Surgeon Longevity in the Robotic Era – Small Setup Changes that Prevent Pain, Fatigue and Errors

Andre Samir Ramkaran, Medical Student, Royal College of Surgeons in Ireland
Neran Mahadeosingh, Medical Student, Royal College of Surgeons in Ireland

By the end of a long robotic list, the silent tax shows up in the same places. A neck that feels two sizes too tight. Shoulders that creep higher with every knot. A lower back that needs a hand on the scrub trolley before the next case. We accept it as part of the craft. It does not have to be.

Robotic surgery gives precision and reach. It also fixes the surgeon to a console where small setup errors repeat for hours. Fit matters. When the console fits the surgeon, attention lasts longer, decisions are cleaner, and the last anastomosis looks like the first. When it does not, the cost is paid in posture, fatigue and avoidable slips.

This is a candid note on what teams can do tomorrow. No new equipment. No lectures. Just a better fit between person and machine.

Why this Matters now

Robotic cases are increasing. Lists run longer. Training seats are precious. The surgeon's body becomes another piece of equipment we must protect. Career longevity is not abstract. It is being able to work a full day and still turn your head on the drive home. Good ergonomics reduce risk for patients and teams.

Three Posture Truths that do not Change

Neutral neck wins. If your chin is poked forward to see the screen, the setup is wrong. Bring the viewer to eye line so your gaze meets the centre of the display with your head level. A neutral neck buys hours of comfort that no painkiller can buy later.

Support the elbows. Floating elbows drain energy. Rest forearms on the console pads or add simple gel supports. Supported elbows steady the hands and refine fine movements.

Feet know the map. Pedal errors happen when feet hunt for the right spot. Set footrests so hips and knees sit at ninety degrees and agree a standard pedal layout across lists. Mark the floor if needed. Consistency builds muscle memory.

Five Micro-moves Before the First Incision

1. **Fit check in sixty seconds.** Sit. Plant both feet. Adjust seat height until hips and knees are level. Bring the viewer to eye line. Rest forearms. Touch the grips and breathe once. If anything tenses, adjust again. Say "fit check complete" so the team hears it.

2. **Eyepiece rule of thumb.** You should see the full circular field without squinting or reaching. If your forehead presses into the viewer, it is too far. If you lean in to avoid a shadow, fix the light or angle now. Do not fight the view for four hours.

3. **Hands that float only when they should.** Grips should meet relaxed hands. If wrists bend up or down to reach, move the armrests. Keep the wrist straight when you open and close. Neutral wrists protect tendons and steadiness.

4. **Pedal rehearsal.** With the menu still up, close your eyes and tap the sequence you will use. Coagulate. Cut. Camera. Energy mode. Do it twice. If a tap is uncertain, reposition the pedal or add a small tactile cue.

5. **Micro-break protocol.** Between docking steps, call a sixty-second break. Shoulders up, back and down. Head left and right, slow and full. Hands open and close. One minute resets an hour. The list will not run late because of it.

It is choreography, not kit.

Team Cues that Make the Fit Stick

Surgeons cannot babysit posture mid-case. The team helps.

Scrub cue. "Fit check complete?" before time out. Polite and firm. It normalises setup.

Anaesthetic cue. "Micro-break now?" during a natural pause. Thirty seconds to reset posture and scan pressure points and hydration.

Circulating cue. A small checklist at the console: seat, viewer, elbows, pedals, break. A touch on that list can save a neck.

Trainee cue. The trainee copies what they see. Ask them to adjust their console too. Small habits learned now pay back for decades.

Small Kit that Helps Without a Purchase Order

Most of this is free. If you add anything, keep it simple.

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- **Gel elbow pads** when standard pads wear down.
- **Footrest wedge** to keep hips and knees at ninety degrees for shorter surgeons.
- **Non-slip pedal mat** with a taped outline so nothing drifts.
- **Timer on the tower** set to beep every forty-five minutes as a micro-break nudge.

What to Measure, Quietly

You do not need a study to know if this helps. One whiteboard in theatre is enough.

- **Discomfort score** before and after the list, neck and shoulders, zero to ten.
- **No-pain weeks** as a simple count. Aim to increase it across the team.
- **Pedal errors** noted discreetly. If they drop after a layout change, keep the change.
- **End-of-list quality** as a quick self-rating. The goal is that the last case feels as precise as the first.

These numbers are for the team, not for publication. They tell you if the fit is working.

Pitfalls to Avoid

Hero culture. If the first hour feels wrong, adjust. Do not push through because everyone is watching. Pause now rather than correct later.

One size for all. A setup that suits one surgeon can harm another. Save profiles by name if possible. If not, mark pad positions with discreet tape.

Fighting the light. Do not lean forward to cope with glare or shadow. Fix the source, not the symptom.

Forgetting the feet. Neck and shoulders get attention. Feet cause errors. Rehearse the pedal map every time.

A Moment that Changed our View

During a valve case, the consultant paused before time out and nudged the viewer by less than a centimetre. He sat back, rested his elbows and smiled. The list ran long, but his posture never collapsed and the last suture looked like the first. It was not magic. It was a sequence. Fit, then focus. As students at the edge of the room, we could see the difference.

Closing Thought

Robotic skill grows on the days you can keep. Protect the surgeon and you protect precision, teaching and patient safety. Fit the console to the person, write the micro-break into the day, share simple cues, and measure quietly. The body will thank you now. The service will thank you in ten years. ■

Home by Day 30: the Metric that Moves Teams — How One Simple Number Focuses Care and Shortens Stays

Andre Samir Ramkaran, Medical Student, Royal College of Surgeons in Ireland
Neran Mahadeosingh, Medical Student, Royal College of Surgeons in Ireland

The operation went well. The valve clicked crisply on echo. The notes read "uncomplicated course." Yet John spent nine extra days wrestling with pain, drains, confidence and the stairs at home. On paper we succeeded. At home it did not feel like success.

Days Alive and Home at 30 days (DAH30) asks a simpler question: in the first month after surgery, how many days did the patient spend alive, in their own home, living their life. Start at thirty. Subtract days in hospital, subtract days readmitted, subtract days in any place that is not home. What remains is the number most patients would choose if they could. It blends what patients feel with what services can change. Survival, complications, mobilisation, discharge planning and readmissions are no longer separate scorecards. They are one story. When teams start speaking DAH30, ward rounds change, priorities shift and small habits begin to add up.

Why it Matters this Winter

Winter magnifies everything. Beds are tight. Flow stutters. Families are tired of long recoveries that feel aimless. DAH30 reframes success in terms that clinicians recognise and patients trust. It pulls attention to the work that shortens stays safely and keeps people home once they leave. Early chest drain removal with clear criteria. Analgesia that enables movement rather than sleep. A first walk before lunch on day one. Nutrition that

begins while the scar is still fresh. Discharge planning that starts at booking, not at the first "medically fit" note.

DAH30 also travels well between teams. Surgeons see it in the theatre–ward handover. Anaesthetists see it in opioid-sparing plans that still control pain. ICU and ward nurses see it in visible mobilisation goals. Physiotherapists see it in the first stair step. Discharge coordinators and community colleagues see it in the first forty-eight hours at home. Everyone can influence it. Everyone can celebrate it.

Five Moves that Lift DAH30

Begin at booking. Put a two-sentence DAH30 explanation in pre-assessment. Give patients simple actions that pay off later: walking, breathing exercises, iron, smoking cessation, basic strength. Invite them to arrive ready.

Write the day zero script. Decide what good looks like before the list begins. First analgesia review time. First sit-out time. First walk time. Drain criteria. Catheter plan. Glycaemic plan. Put the script in the handover, not just in your head.

Make progress visible. A small board at the bedside that says "Sat out 09:30. Walked 20 metres 12:10. Next walk after lunch." Visibility creates momentum. Families become allies. Patients see progress instead of hours.

Fix predictable potholes early. Atrial fibrillation, pleural issues, glycaemic swings and constipation steal days. Have rapid, standard responses. Do not let a small problem become a five-day saga. Rapid rescue protects DAH30 more than heroics.

Discharge like you mean it. Book the first follow-up call before the patient leaves. Send a one-page medication map home. Confirm community supports. Provide a number that is answered. The first forty-eight hours at home decide whether DAH30 grows or shrinks.

None of this needs a new device. It needs attention, sequence and the belief that a patient making tea on day four is a surgical win, even if no one applauds in theatre.

Say it so Patients feel it

Patients deserve words they can understand. Tell them what success means. "Our aim is to have you alive and at home for as many of the first thirty days as possible." Explain how you will help them get there. "We will manage pain so you can move, remove drains as soon as it is safe, and plan discharge from the start." Be honest about uncertainty. "If a problem arises we will act quickly, because days at home matter to you and to us." Consent becomes clearer when outcomes sound like real life.

What we will Measure Next

Keep it simple and visible. A small run chart of DAH30 on the ward noticeboard. A weekly median and a note on what changed. Track three signals that often move with it: time to first walk, time to last chest drain removal and thirty-day readmissions. Share them in the Friday huddle. Celebrate the first patient who meets the plan. Learn quickly from the one who does not. The aim is not to punish variation but to reduce it.

When it Became Real

Maria was seventy-two, active, worried about losing her stride. She circled "going upstairs without fear" on the pre-op sheet. We wrote it on the board by her bed. Day one was slower than planned. Pain control needed a change. Drains stayed in. She walked anyway, once, then twice. Day two was better. Drains came out after lunch. She smiled on the stairs. She went home on day four with two phone numbers, a clear medication map and a physio plan she could see. Twenty-five days out of thirty at home. That is what DAH30 looks like when it becomes personal.

Pitfalls to Avoid

If we reduce DAH30 to a target, we will chase discharge at the expense of safety. Keep it as a conversation tool, not a quota. If we bury it in dashboards, we will lose the bedside. Keep it close to patients. If we make it a surgeon-only metric, we will miss its point. Share ownership. If we wait to make it perfect, we will never begin. Start, learn, simplify, continue.

An Invitation to Teams

The Bulletin thrives on what is happening in the specialty, not on academic debate. DAH30 is a practical, humane way to talk about outcomes in cardiothoracic surgery that patients understand and teams can change. If your unit is trying it, write in with your experience. What moved fastest. What surprised you. What you stopped doing. What you will keep. If your unit has found a better patient-centred measure, share that too. We are all trying to measure the same thing, which is the shape of a month that feels like life again.

Closing Thought

Surgery restores anatomy. DAH30 helps restore days. Count what patients feel, then build care around that count. When we do, the stories on paper and the stories at home finally match. ■

"DAH30 travels well between teams. Surgeons see it in the theatre–ward handover. Anaesthetists see it in opioid-sparing plans that still control pain. ICU and ward nurses see it in visible mobilisation goals. Physiotherapists see it in the first stair step. Discharge coordinators and community colleagues see it in the first forty-eight hours at home. Everyone can influence it. Everyone can celebrate it."

Obituary:
Professor Keyvan Moghissi 1927–2025
B.Sc., M.D., M.S. (Chir), F.R.C.S., (Ed.), F.R.C.S. (Eng.) F.E.T.C.S.
Membre Etrager de L'Academie de Chirurgie, Paris; Consultant Cardiothoracic Surgeon; Consultant in Laser Surgery and Photodynamic Medicine

Keyvan Moghissi was born in Persia – now Iran – before his family moved to Switzerland. Having married an English nurse, he moved to England in the 1950's and leaves a son and two grandsons.

Professor Keyvan Moghissi, studied medicine at the University of Geneva and trained in Cardiothoracic Surgery in four of the London hospitals, namely Hammersmith Hospital, Harefield Hospital, Great Ormond Street Children's Hospital and Middlesex Hospital. His first consultancy in cardiothoracic surgery was in Hull in 1970, when he established open heart surgery at Castle Hill Hospital, Cottingham, which became the Humberside Cardiothoracic Surgical Centre.

In 1982 he was honoured to receive Membre (Etranger) de l'Academie Nationale de Chirurgie (Paris). The same year he was awarded FRCS (England/ad Eundem). He is one of the founders of the European Association for Cardiothoracic Surgery (EACTS) and was its President in 1987.

From 1989 to 1997 he held the appointment of Honorary Professor in Laser/Engineering at the University of Hull.

Having brought Cardiac Surgery to East Yorkshire and developing a thriving cardio-thoracic surgical department at Castle Hill Hospital, Keyvan Moghissi realised that in other countries treatments were available which were not available to his patients. In 1985 he persuaded a group of local businessmen to set up the Laser Trust Fund (Moghissi) Reg. Charity No. 326689. The aim was to develop innovative surgical/laser procedures which were felt to be too expensive to be funded by the Health Service. Through this he became the first surgeon in the UK to use NdYAG laser in thoracic surgery.

Having attracted support from Yorkshire Cancer Research to begin a trial into Photodynamic Therapy, he embarked upon this form of laser therapy which was new to the UK. Prof Moghissi's team were part of the European trial, undertaking more than half of the total work. This research led to EU licensing for PDT using the photosensitiser Photofrin.

In 1992, when Prof Moghissi retired from the National Health Service, he committed himself totally to patient-based research. To further this, in 1997, he was responsible for the formation of the Yorkshire Laser Centre – the working arm of the Moghissi Laser Trust. It is dedicated to patient treatment, research and training in the use of clinical laser therapy.

In addition to this, he developed a mobile laser service which is unique in Europe and possibly even the world. This offers treatment to patients within their "home" hospital and support for clinicians who are new to the procedure; it has been used for training in various areas of the UK.

From the time Keyvan qualified as a doctor, he gave everything he could to his medical calling. His patients will attest to this. His belief was that only the best is good enough for those under his care.

Having discovered the potentials of laser therapy he did all in his power to bring it to public recognition, often in the face of retrogressive attitudes from colleagues.

> **"From the time Keyvan qualified as a doctor, he gave everything he could to his medical calling. His patients will attest to this."**

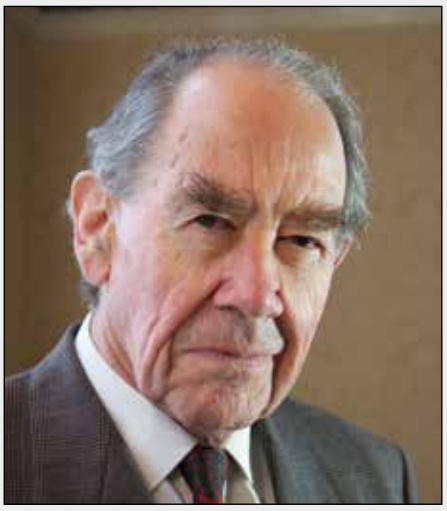
His vision was that clinicians and scientists from around the world should come together to pool their expertise in order to accelerate the pace of progress. In spite of his medical standing he always wanted to know more about his subject and kept in regular contact with colleagues from around the world for information and advice for the sake of his patients.

He passed away on November 13th 2025 aged 98. A true doctor, pioneer and generous soul who will be much missed by his friends, former colleagues and the many grateful patients he looked after in his very long and fruitful career. ■

Obituary: Sir Terence English 1932–2025

KBE DL FRSCE FRCS FRCP

Consultant Cardiothoracic Surgeon and Pioneer of Transplantation



The Society for Cardiothoracic Surgery in Great Britain & Ireland is saddened by the news of the death of Sir Terence English, the surgeon who led the UK's first successful heart transplant and a visionary who extended the boundaries of what cardiothoracic surgery could achieve. He died peacefully at his home in Oxford on 23rd November, aged 93.

Sir Terence performed the landmark heart transplant in August 1979, ending a decade-long moratorium establishing the Cambridge programme and the UK as world leaders. Through determination and courage in the face of scepticism and early setbacks, he strengthened the public and professional image of cardiothoracic surgery, demonstrating our potential to save and transform lives.

Sir Terence was born in South Africa in 1932 and educated at Hilton College, Natal. Having won a Transvaal Chamber of Mines Scholarship to the University of Witwatersrand, he read Mining Engineering, qualifying BSc (Engineering) in 1954. He then came to Britain and studied medicine at Guy's Hospital, where he qualified in 1962. He joined Papworth Hospital in 1972 and became a driving force in the development of transplantation, later contributing to Europe's first heart–lung transplant in 1984.

In 1986 he was awarded the Clement Price Thomas prize for distinguished services to surgery by the Royal College of Surgeons of England. In addition to Fellowship of that College, he was a Fellow of the Royal College of Surgeons of Edinburgh, the Royal College of Physicians of London, the American College of Cardiology, and held Honorary Fellowships of the Royal College of Physicians and Surgeons of Canada, the American College of Surgeons, the College of Medicine of South Africa, the Royal Australasian College of Surgeons, the Royal College of Surgeons in Ireland and the Royal College of Physicians and Surgeons of Glasgow. He was also awarded Honorary Doctorates from the Universities of Sussex, Hull, Nantes and Mahidol in Thailand as well as the University of Witwatersrand in South Africa.

Sir Terence held numerous distinguished roles, including President of the Royal College of Surgeons of England, President of the International Society for Heart and Lung Transplantation, President of the British Medical Association, and Master of St Catharine's College, Cambridge.

He continued to shape global health through humanitarian and educational work long after retiring.

He was knighted in 1991 and was honoured with the SCTS Lifetime Achievement Award in 2009.

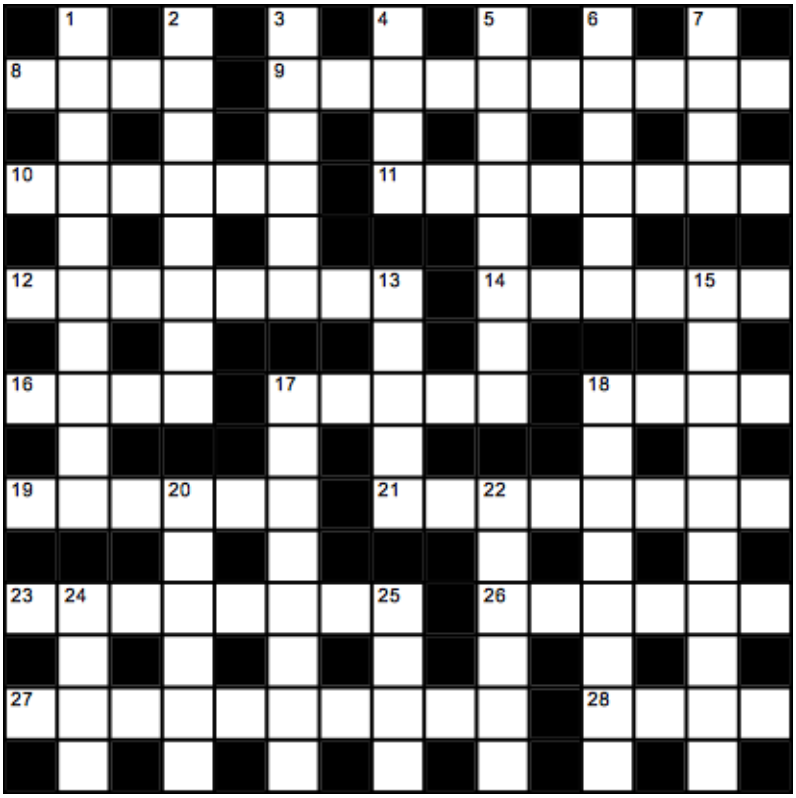
He is remembered as a man of energy, resolve and deep purpose. He is survived by his four children, eight grandchildren and his wife, Judith. He is predeceased by his first wife, Anne. He continued to visit Royal Papworth until recently and is remembered for his charm, humour and being an inspiring figure.

SCTS honours Sir Terence English as a pioneering surgeon, an influential leader and a figure who reshaped and elevated the field of cardiothoracic surgery. ■

"Through determination and courage in the face of scepticism and early setbacks, he strengthened the public and professional image of cardiothoracic surgery, demonstrating our potential to save and transform lives."

Crossword

Set by Samer Nashef



Across

8 Vows left to false god (4)
9 It's standard in Orkneys, perhaps, to be a curtain twitcher (4,6)
10 King rejected the other king (6)
11 Possible clue for S... (8)
12 Assist old boy with coat heading to West Country (8)
14 Silly dunderhead's rewritten lines (6)
16 Nest – having more than one would be rash (4)
17 Within a second, nosebag is empty (5)
18 Golf course reported wild animal (4)
19 Perhaps heady years to begin with? (6)
21 No granny may be free to kiss Nick or Tom's heads (4,4)
23 Coerce into serving the city (8)
26 Increase the minimum of unleaded petrol left in fuel tank (6)
27 Participating in the regatta in Menton is a feat (10)
28 Port Suez returns endless money (4)

Down

1 Excitement of a geek about some cocaine (10)
2 Spot Mrs Fawlty in audition being versatile (8)
3 New wounds caused bleeding hearts (6)
4 Ninety-nine received and understood (1,3)
5 TV producer calling one character at a time (8)
6 Works in arid condition (6)
7 Find cheese, basil, salami at the back of this shop (4)
13 Damn your bra! All clothing comes off in this sort of relationship (5)
15 In enemy retreat with rifle shot cover here (4,2,4)
17 Whatever's like seeing a show on Broadway? (8)
18 Killer on the loose? Admit that's not so far-fetched (8)
20 Rejection of 7 down an abomination (6)
22 Part of me quit yearning for union (6)
24 The American leader is drunk and can't stand (4)
25 Near-perfect concept (4)

Please email solutions by 31/01/2026 to:

isabelle@scts.org ***or send to Isabelle Ferner, SCTS, 38-43, Lincoln's Inn Fields, London WC2A 3PE***

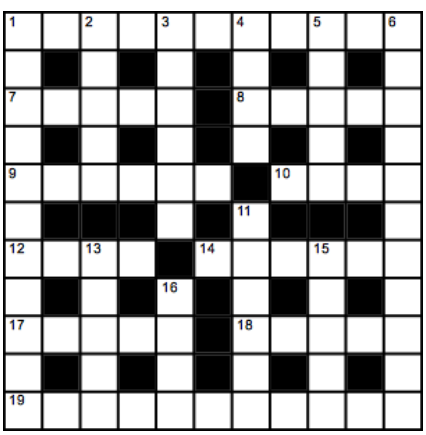
The winner will be randomly selected from successful solutions and will win either a bottle of 'fizz' or fine olive oil.

Congratulations to Richard Milton for winning the August 2025 Bulletin crossword competition (right).

Sudoku

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

Quick Crossword



Across

1 Rural area (11)
7 Kidney-related (5)
8 Offal (5)
9 Not ready to eat (6)
10 Sign (4)
12 Old (4)
14 Stuff thrown overboard (6)
17 Picture (5)
18 See 2 down
19 Holland (11)

Down

1 Blood supply (11)
2/18 Fibres to little and ring fingers (5,5)
3 Flowers (6)
4 Scary snowman (4)
5 Figure of speech (5)
6 2,4,6,8... (4,7)
11 Dog accommodation (6)
13 Precise (5)
15 Warning alarm (5)
16 This place (4)

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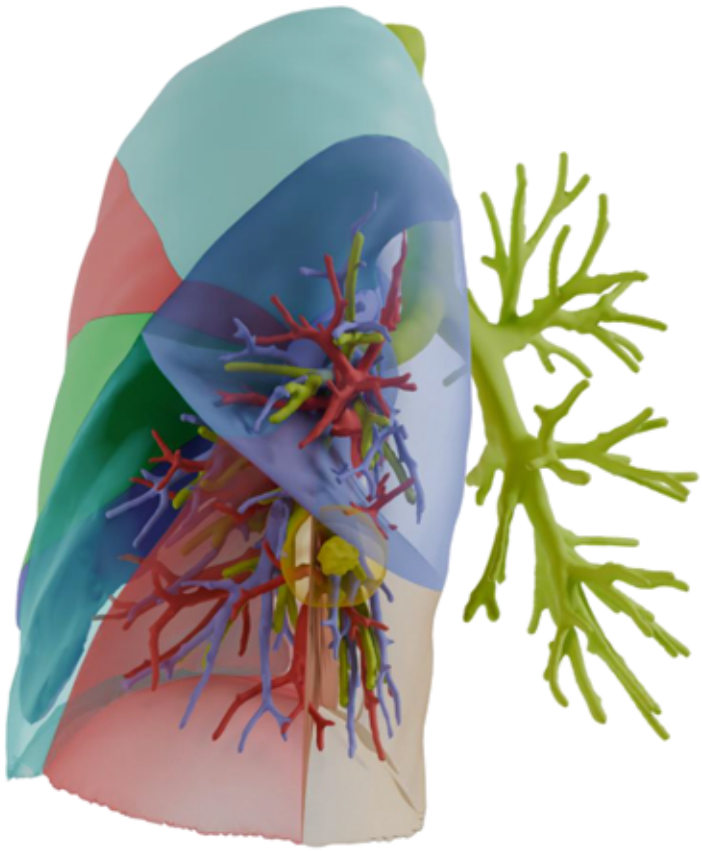

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Reference: Beaver T, Bavaria JE, Griffith B, et al. Seven-year outcomes following aortic valve replacement with a novel tissue bioprosthesis. *J Thorac Cardiovasc Surg.* 2024 Sep;168(3):781-791.

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