the bulletin

Society for Cardiothoracic Surgery
in Great Britain and Ireland

December 2014

SCTS Scholarship in Congenital Cardiothoracic Surgery

SCTS Vision for NCCGs

Thoracic Audit: Developing a Modern Database

Cardiothoracic Training - Core Value

Lung Cancer Surgeons Go Public

Significant Developments in Law and Ethics

Annual Joint Meeting 2015 - Manchester

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President's Address: Tim Graham

Dear all

I am aware that this is the first message from me as the President which will appear in the bulletin. I anticipate that hopefully many of you will be reading this during the forthcoming festive period and I hope that you all if possible take the opportunity for some relaxing holiday time with your family and friends. Around this time of year I think many of us take the opportunity to reflect over events of the past year and consider the up-coming year. Uppermost in many members' and the executive's considerations are with issues related to the clinical audit and publication of surgeons' outcomes.

However, before I consider those issues I think it is important to stress that there is an enormous amount of other positive work going on within the society. The meetings team are pushing on with what looks like is going to be the largest ever annual general meeting of the society in Manchester next March – this meeting is being undertaken in combination with ACTA. Our arrangements with the fund-raising company Scott Prenn are continuing and following a successful showcase day in September this relationship is becoming increasingly helpful for the society. We are planning to have another showcase day with Scott Prenn and potential sponsors and partners for the society at a breakfast session at the AGM in Manchester. However the most positive highlight over the last year has been the activities of the Education Committee, jointly chaired and led by Rajesh Shah and Mike Lewis. They have and are developing an extensive portfolio of education to be delivered by the society and its members to consultants, national trainees, non national trainees and all the other healthcare professionals who are so important to us in delivering high quality care to all our patients.

With regards to the national clinical audit of the three aspects of our specialty, the SCTS Executive has been busy since the annual general meeting in March. We have commissioned a new clinical audit subcommittee of the Executive chaired by David Jenkins which incorporates the national adult cardiac surgery audit, the congenital cardiac surgery audit (David Barron lead) and the evolving thoracic surgery audit (Doug West lead). In June, around the time of the summer Executive meeting, a letter was sent from the Executive to all members of the society acknowledging the disquiet in the membership regarding the publication of surgeon specific data with its potential impact on risk averse behaviour and the working lives of members in adult cardiac surgical practice. This was sent out on the back of events related to data accuracy and local and national validation of cardiac surgery data which had been submitted to NICOR. Then the NHS Choices website publication of the consultant outcome programme in November unfortunately highlighted a red outlier in current clinical practice which triggered unjust and damaging media attention. This outlier status was based on adult cardiac surgery data which was from 2010 – 2013 which is now over 18 months old, since when the results of this surgeon have been excellent. This has highlighted the problems that can occur with the publication of outcome data in this way. The Executive feel that this "car crash" – the red outlier – should be avoided if at all possible for both patient safety and also in the best interests of the consultant cardiac surgeon and the services they work in.

These events during the year culminated in an extended Board of Representatives' meeting on Friday 12 December at the Royal College of Surgeons in London. All members of the society were invited and also the society provided expenses for at least two members from each unit to attend with the intention that this should encourage the unit representatives and the audit leads for each department to attend. The Executive's desire is that this should increase direct communication back towards all members within the units in the UK and Ireland. This was a spirited meeting with over a hundred people in attendance. Sir Donald Irvine (previous President of the GMC) introduced the meeting and gave an overview on patients' perspectives and the surgeon's responsibility to the patients and their families. Ben Bridgewater gave presentations, explaining the relationships between SCTS, NICOR (National Institute of Cardiovascular Outcomes Research) and HQIP (Health Quality Improvement Programme). He also presented on the potential for real time monitoring of surgeons' performance, having a period of steady state bench marking, the current alarm and alert settings and the potential to develop quality markers and practice profiles. David Jenkins gave a detailed update on the current state of the adult cardiac surgical data and audit and discussed the importance of data accuracy, the local and national validation of data and how internal monitoring of performance could be undertaken.

The meetings team are pushing on with what looks like is going to be the largest ever annual general meeting of the society in Manchester next March – this meeting is being undertaken in combination with ACTA.

Steve Westaby presented the position from the recent RSM meeting related to recognising phases of care and "failure to rescue" of sick patients. There was extensive discussion with the membership related to unit and individual outcome reporting and how outliers were identified and the potential way forward. Sarah Murray – our new lay

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President's Address *continued*

representative – gave some closing remarks which praised the members of the society for their work and transparency in this area.

Within our specialty there are two other clinical audits. David Barron and Professor John Deanfield (Director of NICOR) presented the current status of the congenital cardiac surgery audit and how outliers are managed. Congenital cardiac surgery currently reports at the unit and not the individual surgeon level and this was discussed in some detail. Doug West presented on the evolving thoracic surgery clinical audit and the situation with regards to publishing outcomes.

The principal issue for discussion and responsible for significant unrest amongst the membership lies with the reporting of individual surgeons' outcomes and what some feel is the potential to impact upon risk averse behaviour, potentially denying access to surgery for some patients, innovation in adult cardiac surgery and potentially recruitment into adult cardiac surgery as well as the potential impact on individual surgeons' professional and personal lives.

The previous day the Council of the Royal College of Surgeons of England had met where we were represented by Graham Cooper. The consultant outcome programme and publication of unit and consultant surgeons' outcomes on the NHS website was debated. We then had a further meeting with Clare Marx, the President of the Royal College of Surgeons of England, on the morning of the Board of Representatives' meeting to discuss this further. The College of Surgeons' position is that they are agreed that it is not currently possible to pull back from surgeon level publication and that the agenda must be re-focused on quality improvement. They feel that the SCTS is pivotal to this agenda and acknowledge our leadership in this area. We await further details regarding our level of involvement with the college and what their detailed proposals are to communicate the emphasis on quality improvement programmes rather than individual surgeons to all stakeholders including medical directors, the wider NHS management, politicians and the media.

The Executive of the society have considered and discussed this issue considerably, particularly over the last four months, both formally and informally. There are tensions – we acknowledge that – but we feel that we have to be realistic and pragmatic. We are aware that all consultant members responsible for the care of patients wish to drive forward quality improvement – it is our raison d'etre. The consultant outcome programme is not going to go away. There is too much political pressure on senior NHS management at this time. We are certain that if we withdraw from the process then other parties will take it on and their focus is much more likely to be accountability (ie blame) rather than the quality improvement that we wish to see and that could accrue from this process. We feel that we should be proposing a series of actions that will improve quality and act to prevent outliers and also put clinical context around any statistics that have been generated. We are aware that public release of clinical outcome data improves quality of care largely by stimulating institutions to improve. We are aware however that the current approach seems to be more focused on accountability (blame) of individuals – certainly that is how the media look like they wish to see it.

We are the Society for Cardiothoracic Surgery in Great Britain and Ireland and there is a balance to be considered between putting our patients first and also considering the membership of the society. Over the past few months we have discussed in great detail the following – whether the statistical methods are correct; the cardiac surgery datasets including definition and validation and the potential for gaming and also what evidence there is for risk averse behaviour. We wish to avoid outliers (car crashes) for patient safety and also for the membership. In all this we feel it is important to maintain our professionalism and the confidence of all the people around us. The Executive view is that if we withdraw from this process then a vacuum will be created into which others will move (for example Dr Foster). Broadening our range of outcome measures should enable us to focus on success. Developing and sharing robust internal monitoring systems within units will allow us to have a degree of real time monitoring of individuals' performance, to have a bench mark and to avoid unnecessary patient deaths and red outliers. If outcomes are diverging these could be investigated early, potentially with the support of the Royal College of Surgeons Invited Review Mechanism – again the principle of avoiding the problem early rather than dealing with unnecessary aftermath. We want to put clinical context around naked statistics with practice profiles of surgeons, possibly including multi-source feedback that will be available from local appraisal and revalidation processes. The Executive is intending to send out a separate communication early in the new year with regards to proposals from the Board of Representatives' meeting including giving the members the opportunity to upload multi-source feedback on to their profiles and to conduct some form of survey to establish views on wider outcome measures and internal processes of monitoring of performance.

In summary, the outcomes monitoring and reporting agenda is here to stay for the foreseeable future. It is a continuing journey but the SCTS need to stay on board. We need to avoid the car crashes – my wife works for British Airways and I have discussed in principle with her and some BA pilots some of the issues that we are facing – they have reminded me that British Airways have processes and philosophy in place which work towards and state that "all our pilots are safe" – however they put airline safety as their key priority. I would like to think that we could move to this philosophy in our surgical specialty – safe surgeons and patient safety.

The note that I would like to finish on though is that in all of this it strikes me that all of you – my consultant cardiothoracic surgical colleagues in UK and Ireland – are forgetting what a great job you all do and I would like you all to reflect on that over the holiday period going into 2015.

I hope you all have a peaceful and happy holiday period, I wish you all well in your professional and personal lives in the upcoming year and look forward to seeing as many of you as possible (and your unit allied healthcare professionals and nurses) at the joint annual general meeting in Manchester.

Tim Graham
President SCTS

Slides of all the presentations made at the Board of Representatives' meeting on 12.12.14 are available on the members' page on the website.

Honorary Secretary's Report

Simon Kendall

A warm reception in Malaysia

I have just returned from a week in Malaysia. A country that the British colonised from 1819 to 1957 and appear to have left a significant positive influence. In superficial terms they drive on the left, they use UK plugs and most of the 28 million population speak English. More significantly they have a multicultural and tolerant society comprising mainly of Malaysian, Chinese and Indian ethnicity and Muslim, Christian and Buddhist religions. They adore the Premier League !

Professor Steve Clark and myself had been invited to participate and present in their 16th annual cardiothoracic surgical conference. We were most warmly received and overwhelmed by the kindness and hospitality shown to us. They are a thriving multidisciplinary specialist community finding themselves where we were in the UK 20 years ago – huge unmet demand and entering a period of major expansion. Their practice is starkly divided between private practice and government health care and at present it appears to be difficult to be a surgeon and deliver both.

There were two striking observations. Firstly many of the surgeons we met had spent significant time training in the UK. They had an in depth knowledge of our units, our surgeons and our practice. And secondly our training and practice in the UK still has their respect. They are impressed by the structure of training we offer and the quality of the specialist exam.

The Edinburgh Connection

The Royal College of Surgeons of Edinburgh and the Academy of Medicine, Malaysia signed a memorandum of understanding in June this year. This was facilitated by Tim Graham and Pala Rajesh through the President of RCS Ed. The aspiration is to establish National selection, 'in-training' annual progress assessments and Quality Assurance within the 3 units chosen by the Malaysian Association of Thoracic and Cardiovascular surgeons. In addition plans are being developed for Malaysian surgeons to undertake the Joint Surgical Colleges Fellowship exam in Cardiothoracic surgery.

The surgeons we met are delighted with this development as a step towards sustainable quality recruitment to the specialty. Too often it would appear Malaysian surgeons are tempted away by private practice and leave the government sector short changed.

They are contemplating the introduction of a national cardiac database and are interested in our experience so far. They are truly mixed practice, not only doing thoracic and cardiac surgery but also helping with congenital surgery doing Ductus', VSD's and ASD's and are fascinated by our journey to sub specialisation. So all in all it was flattering to see the influence the SCTS has on practice in a country on the other side of the world. We were privileged to be taken to the Health Ministry and introduced to the Director General for Health, Datuk (Lord) Dr Noor Hisham Abdullah, still a practicing Endocrine surgeon who spent time training in Newcastle. He knew the Malaysian surgeons that we were with. He knew the issues facing cardiothoracic surgery and he was interested in all opinions expressed around the table. Here was a tangible link between the clinicians and national policy.

How different in the UK, where we have a health system where the medical staff have been largely ostracised by the administrative bodies. It is quite difficult to meet your own chief executive or medical director let alone meet regional or national leaders. And when you do it's rare that they seem to be really listening.

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Honorary Secretary's Report *continued*

Divergence from outcomes

As a specialty we believe that we have some influence through our leadership on publishing surgical outcomes. In Maintaining patients' trust: modern medical professionalism we clearly defined the role of the contemporary surgeon and the support they need from their organisations. It deals with the many aspects of our professional lives and with regard to performance outcomes it is absolutely clear about the process to explain divergence:

Underpinning these guidelines is that the SCTS/RCS is available to provide independent constructive advice to support surgeons and their institutions to support patient care and protect patients.

Let's remind ourselves of the headlines that got us here: First the Kennedy report (Bristol) and then the Francis report (Mid-Staffs) highlighted that poor outcomes were widely known but were not acted upon. Transparency is about reversing that situation and providing assurance and reassurance. Indeed the Francis recommendations included:

'All healthcare provider organisations should develop and publish real time information on the performance of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction, and on the performance of each team and their services against the fundamental standards'

'It must be a professional duty of healthcare professionals to collaborate in the provision of such information'

and

'This information, available in as near real time as possible to providers, commissioners, regulators and the public, should include not only the statistics of outcomes, but also all other available safety-related information, including that derived from investigations, complaints and incidents.'

In cardiac surgery we can forget how far we have travelled on this journey compared to the other specialties. Our cardiothoracic division in our trust has recently been merged with neurosciences and we now produce a combined governance report. When I say combined I mean that it includes huge amounts of data on cardiac surgery and significant data on cardiology and thoracic surgery. However there is NOTHING about neurosurgery and neurology to include. The clinicians do not know what data to record and nor do they see the relevance of such data to their patients, the public and the wider NHS. This is one example of the gap between us and the rest of the medical profession. This should mean that our experience, and the lessons we have learnt, should be listened to.

The principles of explaining divergence

1. The process must be reasonable and proportionate
2. This process should not lead to patients who are high risk being denied surgery
3. Divergence from expected outcomes should be classified according to its level and frequency
4. Divergence is a cause for looking at the data in more detail and is not, on its own, a reason for restricting a surgeon's practice
5. The mechanisms for supporting a hospital or surgeon and explaining abnormal mortality rates must be separate
6. Explanation should proceed in four stages
   a. Analysis of the data for accuracy
   b. Analysis of the caseload to ensure that the risk stratification mechanism accurately reflects expected outcomes
   c. Analysis of institutional factors that may contribute to the divergence in clinical outcomes
   d. Analysis of the surgeon's performance

However the NHS and the Trusts are fixated on any potential negative stories in the media and therefore feel under intense pressure to react quickly. The media has lauded our openness and transparency but they still can't resist a story – it's their job of course and sells newspapers. They often focus on the personal tragedies of the 3% that have died under our care ignoring the 97% survivors. This is particularly unhelpful to surgeons, their teams and the patients who are treated in those institutions.

Interpretation

So although the fear of the media makes explains the behaviour, it is disappointing to see the adult cardiac surgical data being misinterpreted to:

- restrict surgeons' practice;
- damage their confidence and professional ability;
- deny patients access to their surgeons care;
- put more strain on their colleagues;
- apparently not protecting patient care.

Although the adult cardiac surgical database is a force to improve patient's outcomes, some use of this data is negative. As members of the executive we want to influence the agenda to offer constructive outcomes.

The SCTS needs to be actively engaged from the onset in performance management – the medical directors should seek our advice as the initial step, and avoid making hasty decisions. And we need to be more engaged with NICOR and HQIP who have also verged on premature judgments.

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Honorary Secretary's Report *continued*

Wherever possible the default position should be that surgeons and their teams should be kept operating and treating patients, and only where patient care is significantly at risk should care be suspended. We should explore every possible constructive measure before resorting to restriction or, even worse, exclusion from practice.

Safe Surgery

Safe surgery depends on several factors – knowledge, training, experience and skill but it is also heavily dependent on confidence – an inner confidence in ourselves to take on the responsibility of care and complete the surgery, and external confidence from our colleagues and institutions. These are intimately related and it cannot be underestimated how difficult surgery becomes if either or both are diminished. Medical directors / trusts do not appear to appreciate the impact of restricting practice – no matter how brief a period it might be, as it is a relatively easy action to take compared to tackling the underlying behaviours / team dynamics that are so often much more relevant than the surgeon themselves.

A functioning surgical team with good governance structures will recognise problems at an early stage whereas the dysfunctional team will benefit with the help of the RCS (with the SCTS) to explore constructive measures possibly using the IRM mechanism, and only where team members show an inability to contribute should restrictive measures be necessary.

With the few, but high impact, negative outcomes it is not surprising that the other surgical specialties, including thoracic surgery, are nervous of the publication of surgical outcomes. The experience in cardiac surgery shows the major benefits from the database but also the potential for some significant harm.

It is only right that as professionals we know what we're doing and how well we're doing it. And it is only right that our patients and their relatives know that their surgery is being performed in a safe centre by a safe surgeon and their team. But can this be achieved by reporting unit based outcomes rather than individual surgeon outcomes?

Over the last 10 years our database has shown that we are operating on sicker patients but with significantly less mortality – these are outstanding results of which we should be justly proud. The demonstration of improving outcomes is evidence enough that it has been a successful project and should continue to be fundamental to our practice and our specialty. It is an iterative process which continues to be refined as seen by the current scrutiny on the definitions of risk factors – and we can work together to get through these problems.

Cardiothoracic surgery has changed since the database was set up – MDTs are now prevalent in the decision making for patients and the critical post-operative care is largely done by intensivists. The surgeon is not the 'lone practitioner' that they once were. Steve Westaby has eloquently described this in his BMJ article about the 'phases of care' and that the modern day cardiac surgeon plays a much lesser role in patient outcomes.

Whilst there is a sentiment among some surgeons that outcomes at a unit level are more relevant to the patients and the public – as long as that team is functioning effectively to influence individual practice - we cannot unilaterally move from publishing surgeon to unit outcomes. There are multiple stakeholders and most importantly the regulators themselves. We will need to engage with them to discuss the merits and pitfalls. The opinion of patients will also be vital, and through the RCS we will need to lobby patient groups and inform them of our opinions, reassuring them of safety and transparency.

It is not surprising that the other surgical specialties, including thoracic surgery, are nervous of the publication of surgical outcomes.

The professional societies, balanced with lay and patient representation, are best placed to understand performance outcomes, and recommend constructive measures if necessary. It is not clear that the NHS recognises this.

So on the one hand the SCTS has great influence – and it has been a privilege to witness that influence in Malaysia. However we must not lose influence in our own country. We must work together to maintain the influence and control that supports surgeons and their teams to carry on treating patients and protect patients at the same time.

The views expressed regarding the adult cardiac database are shared by Tim Graham (President), Graham Cooper (President elect), David Jenkins (Chair Data Committee) and David Barron (Chair Congenital Sub Committee).

SCTS Scholarship in Congenital Cardiothoracic Surgery

Michael Murphy
ST8 London Deanery

I have just completed an extremely enjoyable, productive and rewarding experience during the six months of an SCTS scholarship in congenital cardiothoracic surgery in London. From December 31st 2013 to June 30th 2014, I operated on three sites across London and benefited from a fascinating and diverse exposure and experience in congenital surgery.

I am in my final year of training and have chosen to specialise in congenital surgery. My choice of sub-specialty had been heavily influenced by my time working with great surgeons and trainers in Boston, Philadelphia and at St. Thomas'/Evelina London Children's Hospital. Leading up to the scholarship I had had three years of congenital training and felt I was close to being ready for independent practice. I was keen to take advantage of the very generous funding supported by Ethicon, and felt, having been abroad twice before, that I would seek out training and learning locally.

I had looked through my portfolio and felt that I should focus on neonatal and adult congenital surgery. I also wanted to prepare for consultant interviews and learn some of the morphology I should have already known! Prof Anderson and Mr Austin were extremely supportive in organising for me to continue my excellent training at St. Thomas'/Evelina two days a week, focusing on neonatal surgery. As I had worked with them previously, this allowed me to hit the ground running.

St Thomas' Hospital & Evelina London Children's Hospital

My experience at St. Thomas'/Evelina was complemented perfectly by operating with Mr Tsang for one day a week at the Heart Hospital, doing adult congenital surgery (or grown-up congenital heart disease – GUCH) and one day a week at Great Ormond Street, seeing first hand how they operate on and manage their neonates. The GUCH practice at the Heart was one of the first in UK to be established and runs a high quality, high volume service dealing with a fascinating spectrum of adults having anything from a first time operations for ASDs or a cone repair for Ebstein's malformation to patients having sixth time redo's for pulmonary valve replacement, aortic aneurysm repair or re-intervention after Ross procedure.

The Heart Hospital, part of UCLH & Great Ormond Street Hospital

During the scholarship I took advantage of my position as a supernumerary registrar, to attend a large number of operating lists, while still being able to attend the ACHD and Paediatric MDT's that I had often been to busy to get to during full time clinical posts. The MDT's provided me with a great exposure to decision-making and management of children and adults with complex congenital heart disease.

I was involved in surgeries for a vast array of congenital conditions, in particular staged palliation including hybrid procedures for hypoplastic left heart syndrome, pulmonary autograft and valve repair techniques for congenital aortic stenosis, the cone repair for Ebstein's anomaly, valve sparing tetralogy repair, neonatal arch repair, extra-anatomic repair of arch obstruction and valve sparing aortic root replacement. I added to my logbook considerably, including highlights such as the arterial switch operation, interrupted aortic arch repair, repair of hypoplastic arch and repair of total anomalous pulmonary venous drainage.

> *I operated on three sites across London and benefited from a fascinating and diverse exposure and experience in congenital surgery.*

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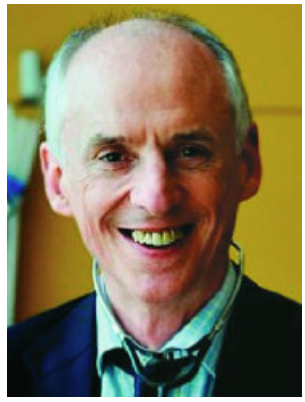
SCTS Scholarship..... *continued*

I also had the opportunity during the scholarship to visit the Columbia program at NY Presbyterian Hospital, where I observed the practice of Drs. Bacha and Quaegebeur. This was an excellent experience, and I particularly enjoyed their diverse neonatal practice in a well-run, high quality congenital program. During this visit I was also able to attend the Aortic Symposium, which was informative of the best practice in the aortic problems that bedevil many ACHD patients after tetralogy repair, arterial switch and with connective tissue diseases. I was also able to attend the AATS where the congenital postgraduate symposium, congenital skills course, and congenital sessions demonstrated the "state of the art" practices of the best centres in the world.

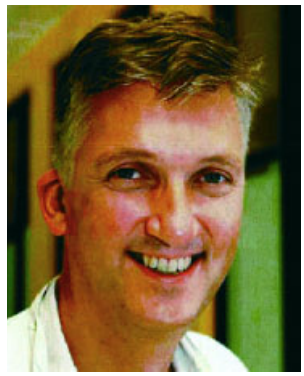
Towards the end of the fellowship I attended a three-day morphology course that was a great refresher for some of the more complicated morphologies that I had seen through my training and a bit of an eye opener about how much I had still to learn!

I am indebted to the patience and commitment of my surgical trainers, Prof Anderson, Mr Austin and Mr Tsang. I am grateful to the society and Ethicon for the opportunity learn so much during the six months. The registrars at the three institutions were incredibly understanding and flexible given the unusual nature of my role on each site.

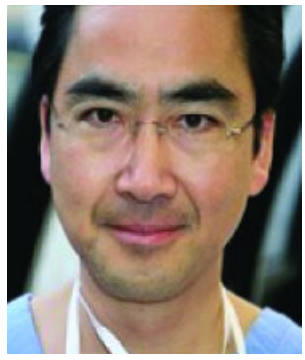
I could not recommend the scholarship program highly enough to other registrars to get some focused and specific training to get them ready for consultant post – please take some advice and get planning now.



Prof Anderson



Mr. Austin



Mr. Tsang

SCTS Vision for NCCGs

Mr M S Kalkat
Consultant Thoracic surgeon, Birmingham Heartlands Hospital (NCCG Lead SCTS Education)
Mr S Rathinam
Consultant Thoracic surgeon, University Hospitals of Leicester and SCTS Thoracic Surgery Tutor

Concept

SCTS Education's vision is to offer education and training courses to all the multi-professional staff of our wide speciality.

The Cardiothoracic medical workforce comprises of Consultants, trainees and non- consultant career grade doctors. There are various programmes which are aimed at Consultants and the Trainees have formalised a structured curriculum based courses for the trainees under the auspices of the SCTS education developed by the Tutors.

The NCCG doctors do not get opportunities to attend meetings and the funding is limited, moreover they provide the service allowing the trainees to attend these educational events.

SCTS Education has addressed this gap in their training needs by constructing a course aimed specifically for NCCGs in CT Surgery which covers both clinical and professional aspects.

The first step in that venture was the NCCG Symposium.

SCTS NCCG Symposium

Course Directors:

Mr M S Kalkat, Consultant Thoracic surgeon, Birmingham Heartlands Hospital (NCCG Lead SCTS Education)

Mr U Dandekar, Consultant Cardiac surgeon, University Hospitals of Coventry and Warwickshire

Mr S Rathinam, Consultant Thoracic surgeon, University Hospitals of Leicester and SCTS Thoracic Surgery Tutor

The course was held on the 8th September 2014 in the Clinical Sciences Building University Hospital, Coventry. It was supported with an educational grant from Covidien which allowed the SCTS Education to offer this free to the delegates.

28 delegates attended the meeting with a good spread from various units across the United Kingdom. The symposium ran well completing the learning objectives of meeting. The faculty were very enthusiastic and informative in supporting and coaching the delegates.

The course had four themed section, the first focussed on Professional affairs covering Portfolio, Appraisal process, Supporting professional activities and CESR.

The next session was run as cardiac and thoracic themed parallel clinical sessions. The cardiac theme had updates on Coronary surgery, Valve surgery and TAVI and Aortic surgery. The Thoracic surgery theme had similar updates on Lung cancer, minimally invasive surgery and Chest wall surgery.

The third session initiated with a SCTS NCCG Interaction followed by patient safety issues covering informed consent and patient safety and Complaints process.

The Final session had a brief introduction to Effective interview technique followed by small group mock interview.

Programme

1 Professional Affairs

Maintaining a portfolio and Appraisal process in the Era of Revalidation Mr U Dandekar, University Hospitals Coventry

How to enhance your career with supporting professional activities Mr S Rathinam University Hospitals Leicester

CESR: Rules and Regulations Specialist registration through article Mr PB Rajesh , Birmingham Heartlands Hospital

2a Cardiac surgery

Coronary surgery: Mr A Szafrenek, Nottingham University Hospitals

Valve surgery and TAVI Mr S Billing, Newcross Hospital Wolverhampton

Aortic surgery Mr L Balacumaraswami, University Hospitals of North Staffordshire, Stoke on Trent

2b Thoracic surgery

Lung cancer Mr KS Rammohan, University Hospitals of South Manchester

Minimally invasive surgery Mr S M Woolley Consultant Thoracic Surgeon, Liverpool Heart and Chest Hospital

Benign and Malignant Chest wall condition Mr MS Kalkat Consultant Thoracic surgeon, Birmingham Heartlands Hospital

3 NCCG and Patient Interaction

What SCTS can do for you and what you can offer SCTS Mr S Kendall, James Cook University Hospital Middlesboro

Obtaining informed consent and patient safety Mr R S Steyn, Associate Medical Director, Birmingham Heartlands Hospital

Complaints process in the NHS Mr R S Steyn, Associate Medical Director, Birmingham Heartlands Hospital

4 Interview Techniques

Effective interview techniques Mr U Dandekar, University Hospitals of Coventry and Warwickshire

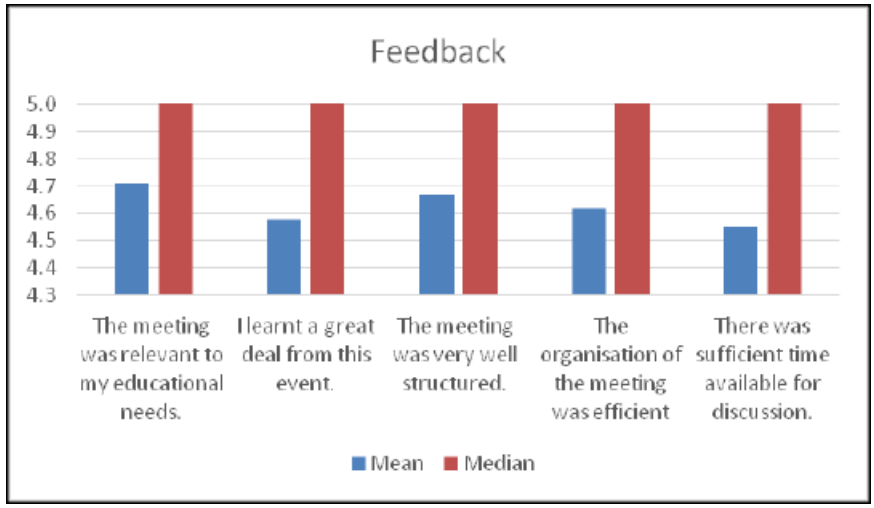
Small group mock interview

SCTS for NCCGs..... *continued*

Feedback

The faculty feedback was very positive with various suggestions to improve the course.

The delegate feedback was very positive both about the course content as well as the faculty's style of delivery with a majority rating it as excellent and the rest as very good (Scale of Poor-1-5 Excellent).



Future

The society appreciates the contribution of the NCCG doctors towards management of cardiothoracic patients and maintaining high standard of care and quality. SCTS Education has a NCCG lead and hence following important decisions have been made.

The NCCG members will be offered the following benefits:

1 There will be concerted effort to encourage NCCG doctors to get involved with society, its activities and development. The suggestions from the group will be welcomed and implemented to take this forwards.

2 We aim to offer two free courses per year, one based on clinical component and the other on professional development. The funding for these two courses have been secured and the plantis to hold them in April and September respectively.

3 There is provision of two NCCGs fellowships of £5000 each for suitable candidates to pursue their career.

4 A working group to be formed to discuss the issues pertinent to NCCG doctors and explore future developments.

This will only be possible if NCCGs become members and engage with SCTS.

We seek assistance in circulating this to Clinical Fellows, Staff grades and Associate Specialists you know, or work with or have contact details.

We will also appreciate if you could help us in developing the database of the NCCG doctors working in UK and Ireland, by forwarding me their contact details.

Thoracic Audit
Developing a Modern Database

Doug West
SCTS Thoracic Audit Lead

Thoracic surgical audit is in the middle of major change, as we move from the SCTS returns, our long-running registry, to a comprehensive clinical database. This article outlines what has been achieved, and current work to develop a database that will audit outcomes, drive quality improvement and aid research.

HQIP and Consultant Outcomes Publication by NHS England

In 2014 HQIP asked units to validate their activity in the National Lung Cancer Audit (NLCA). Thank you to all who took part.

In this first year, the Society successfully argued that the data was not robust enough to report surgeon-specific data, principally because it was not risk adjusted. However, it is clear that the Consultant Outcomes Publication project (COP) has surgeon-specific outcomes reporting as its goal. Other specialties have reported publicly this year; we will not be far behind. Can the SCTS still influence the direction of thoracic audit? I am sure that we can, and should, be directing future progress.

Developing the SCTS Database

We can be proud of the SCTS returns. A national registry running for over 30 years, it is one of the world's largest thoracic surgery datasets, run without external funding through the goodwill of our members. If you haven't seen the data recently, go online and download it at www.scts.org/professionals/audit_outcomes/thoracic.aspx

However, without risk stratification and long-term data its usefulness is limited. We need to follow other surgical specialties and build a comprehensive national database.

Unit-level outcome reporting is important if we aim to really improve care. Units, rather than individuals, have enough data to provide adequately powered comparisons quickly, remembering that most thoracic surgeons only perform between 30-60 major resections/year, and mortality is thankfully rare. It is at unit level that most quality improvements can be made; from developing pre-operative assessment clinics to effective peri-operative protocols.

The NLCA (LUCADA) has delivered major improvements with just such a team-based reporting strategy. Modern surgery should be based on team working, not on surgeons practising in isolation. The structure of our audit should reflect this.

Surgeons are best placed to build robust audits; they often understand the improvements needed and the barriers to change. The SCTS must remain a leader in developing surgical audit, making our voice heard for patients.

The National Lung Cancer Audit

The NLCA is now applying for another three years of HQIP funding. SCTS is supporting this bid, believing that a close relationship strengthens both audits. Knowledge of a unit's resection rate (from the NLCA), and its outcomes and comorbidity profile from the SCTS gives, we believe, a fuller assessment of performance.

Get Involved

The GMC has funded the SCTS database to support revalidation of thoracic surgeons. We have commissioned Dendrite to develop the database and a secure web-based portal. The portal, and facilities to receive whole-unit data are both now available. Work is underway to report long-term survival by linking to other NHS data sources. Login details can be obtained direct from Dendrite (support@e-dendrite.com) or through me at doug.west@bristol.ac.uk

It is now a priority for all units to submit to the database. Submission will almost certainly be mandated by this year's NHS England Commissioning guidelines.

The database needs input from across our subspecialty. I am grateful to Joel Dunning, Carol Tan and Eric Lim for forming a new working group. We have also had useful input from Mick Peake at the NLCA, Ben Bridgewater at NICOR, David Mitchell from the Vascular Society and others.

Symposium at SCTS/ACTA 2015

There will be a symposium on the database at the 2015 Annual meeting - come along and have your say.

I finish by paying tribute to Richard Page's decade of hard work as audit lead. He produced our first two national audit reports, developed the new database and led the recent HQIP project for SCTS. We are in his debt.

If I can help, please contact me at the email above.

SCTS Education

Portfolio of SCTS / SAC Curriculum-aligned Cardiothoracic Surgery Training Courses

Narain Moorjani
SCTS Cardiac Surgery Tutor
Sridhar Rathinam,
SCTS Thoracic Surgery Tutor

- The Key principle is to deliver a programme of continuing learning for Cardiothoracic Surgery Specialty Trainees
- Portfolio of 12 core courses (2 per year over the ST3-8 years) will be mapped out to mirror the ISCP Cardiothoracic Surgery curriculum, delivered through small group teaching, wetlab simulation and live operating simulation, as well as web-based progress monitoring
- Courses have been endorsed by SCTS Education, Cardiothoracic Surgery Specialty Advisory Committee (SAC) and Training Programme Directors (TPDs)
- Attendance at these courses by the trainees will be strongly encouraged and monitored through the ARCP process
- Course fees, accommodation and certain travel costs will be funded through an educational partnership with Ethicon, Sorin and other industry partners.

ST3	Introduction to Specialty Training in Cardiothoracic Surgery Course	Cardiothoracic Intensive Care and Surgical Access Course
ST4	Core Cardiac Surgery Course	Core Thoracic Surgery Course
ST5	Intermediate Viva Course	Non-Technical Skills for Surgeons (NOTSS)
ST6	Cardiac Surgery Sub-specialty Course	Thoracic Surgery Sub-specialty Course
ST7	Revision / Viva Course for the FRCS (C-Th)	Birmingham or London Core Review Course (provided externally)
ST8	Cardiac Surgery Pre-Consultant Course Thoracic Surgery Pre-Consultant Course	Professional Development Course

24th – 26th Nov 2014 **Introduction to Specialty Training in Cardiothoracic Surgery Course (ST3A)**
Sorin National Wetlab Centre, Gloucester
Course Directors: Narain Moorjani / Sri Rathinam / David McCormack

1st – 3rd Dec 2014 **Core Cardiac Surgery Course (ST4A)**
Sorin National Wetlab Centre, Gloucester
Course Directors: Clinton Lloyd / Joseph Zacharias / Narain Moorjani

21st – 22nd Jan 2015 **Intermediate Viva Course (ST5A)**
J&J Pinewood Campus, Wokingham
Course Directors: Donald Whitaker / Kelvin Lau / Narain Moorjani / Sri Rathinam

9th – 12th Feb 2015 **Cardiothoracic Surgery Sub-Specialty Course (ST6A and ST6B)**
European Surgical Institute, Hamburg, Germany
Course Directors: Narain Moorjani / Sri Rathinam / Enoch Akowuah / Maninder Kalkat

2nd – 5th March 2015 **Revision & Viva Course for the FRCS (C-Th) (ST7A)**
J&J Pinewood Campus, Wokingham
Course Directors: Max Baghai / Doug West / Sri Rathinam / Narain Moorjani

20th – 22nd May 2015 **Cardiothoracic Intensive Therapy and Surgical Access Course (ST3B)**
European Surgical Institute, Hamburg, Germany
Course Directors: Joel Dunning / Neil Roberts / Colin Moore

22nd – 24th June 2015 **Core Thoracic Surgery Course (ST4B)**
Minimal Access Therapy Training Unit (MATTU), Guildford, Surrey
Course Directors: Tom Routledge / Sri Rathinam

Cardiothoracic Forum

@ the SCTS Annual Meeting - Manchester

Christina Bannister
SCTS Nursing & Allied Health Professional Representative

March 2015

The 2015 annual meeting is planned to be held at the Manchester Conference Centre. This will be the second combined meeting with ACTA (Association of Cardiothoracic Anaesthetists), and will once again give all Cardiothoracic Forum participants the opportunity to network with nurses and allied health practitioners from all aspects of cardiothoracic care, including those working in theatres and on cardiothoracic intensive care and high dependency units.

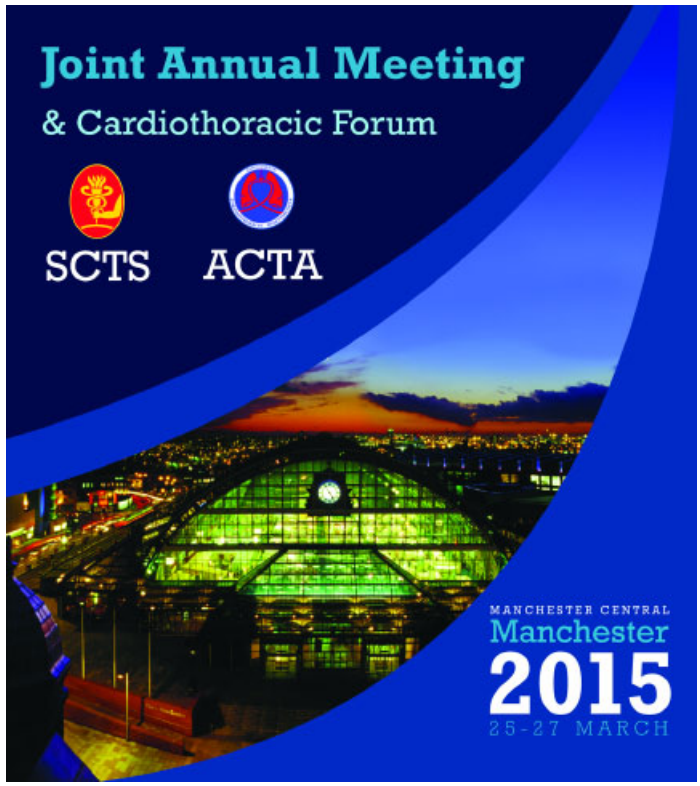
This year's forum will look at aspects of work across the entire spectrum of cardiothoracic care as they relate to the patient's journey. As this is a joint meeting we are planning again to offer one free registration for every five booked.

This years meeting is planned to run over the entire three days in March; starting with a Nursing and Allied Health Professional stream at the joint SCTS University and ACTA Academy. This will be the first time we have had a stream at the University and we have a full practical day planned. The University will be split into a half cardiac / half thoracic day, which will enable participants to either take part in the entire day; or join for either the morning or afternoon session and then attend another University stream session with other delegates. Kevin and his team from Wetlabs are working alongside us to provide an exciting and educational session for all participants; and we have an international faculty planned with professionals from Nursing and Allied Health backgrounds attending from the United States, Europe and the UK.

We have been working hard selecting the papers for this year's CT forum presentations during the main meeting. We had a record number of abstracts submitted this year, from a wide group of participants ranging from advanced nurse practitioners and SCP s to theatre nurses and critical care practitioners. This will enable us to examine in-depth all aspects of care related to cardiothoracic patients and will give us an enhanced breadth of knowledge from all nursing and allied health specialities as we link with the anaesthetists throughout the meeting.

We have a number of fascinating plenary sessions planned for March 2015. The President of the RCN, Andrea Spyropoulos will again be attending to give us an up-to-date nursing perspective, and with her will be Cecilia Anim, who is taking over from Andrea as the new RCN President as of January 2015. We also have a session planned which has been requested from a number of delegates at last year s conference. The 2015 joint SCTS/ACTA meeting is the prime time to listen to the patient s perspective of undertaking cardiothoracic surgery, alongside the surgeon, anaesthetist and nurse involved in the case to provide a clinical narrative of the patients' experience. We have previously had extremely interesting, entertaining and insightful patients attending our meetings, and we hope next year's patient will continue to provide an excellent experience.

Each CT Forum we have held has been a big success. We have gained a network of core nurses and allied health professionals



across the country that have in interest in progressing training, development and service provision with cardiothoracic surgery, from a wide range of backgrounds; from nurses, medical staff, surgical care practitioners, physiotherapists, physician assistants and other allied health professionals across the country. I would like to take this opportunity to thank in advance all the plenary speakers, chairs, presenters and participants without whom the CT Forum could not exist. Not only do we all learn from others at the Forum but the networking and shared working practice information that we all get is invaluable. We look forward to a large number of participants attending the CT Forum in Manchester and I urge you all to encourage your colleagues in nursing and allied health professional specialities to attend also.

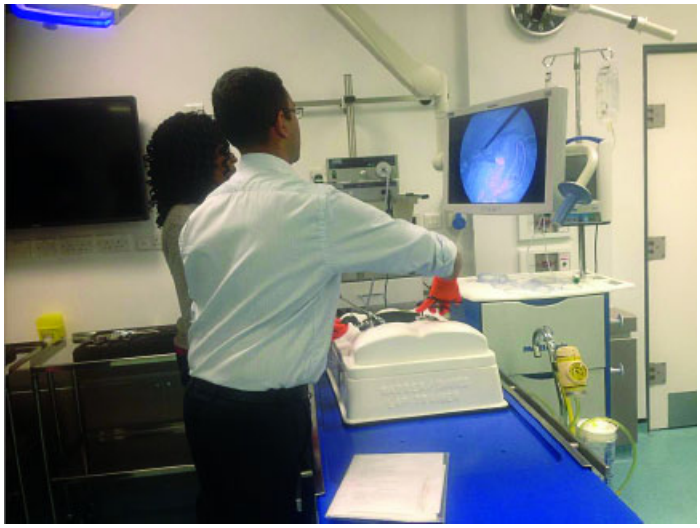
Surgical Care Practitioner Update

Consultations with the **Surgical Care Practitioners** remain ongoing, currently there are many streams of work progressing.

The Ethicon Master Class in Conduit Vein Harvesting in collaboration with SCTS/ACSA education took place on the 3rd of November 2014 at the Manchester Surgical Simulation Centre, Manchester. 28 delegates attended the course which covered computer endoscopic skills, ultrasound teaching, and cadaveric experience of vein and radial artery harvesting. Present at the course were Simon Kendall, Mike Lewis and Rajesh Shah from SCTS and key members from ACSA. Clinical international trainers from Maquet, Sorin, Terumo, Sonasite and Karl Storz also attended the day to train the delegates and to give support to

Cardiothoracic Forum

@ the SCTS Annual Meeting 2015 - Manchester



the faculty. We thank all the companies for putting so much effort into the training, and we also thank Ethicon for sponsoring the course. Feedback from the course was excellent with almost 95% of delegates very satisfied and 5% of delegates satisfied with the course. The full details from the course feedback will be presented at SCTS/ACSA meeting in Manchester in 2015.

Following consultations with the Royal College of Surgeons of Edinburgh, the SCP exam will be held in December 2014, based upon the current SCP exam structure and questions. There will also be a revision course held prior to the exam. Work is ongoing to update the SCP course for the 2015 exam, with a rigorous QA process being developed. Thanks go to the RCS, Edinburgh for all their help, support and backing for this process.

EACTS

The postgraduate nurses' day at EACTS was once again run by nurses and allied health professionals from the UK and the Netherlands. This was held in Milan on Sunday 12th October 2014. The SCTS CT Forum top marking presentations were invited to present at this meeting, and Joel Dunning gave a fascinating and entertaining lecture on up-to-date advances within the CALS course. There was attendance from nurses and health care professionals across Europe and it was a great opportunity to link and network with them.

The EACTS Quality Improvement Programme (QUIP) programme still continues – looking in-depth at quality standards across Europe with the concept to bring together common aspects and setting a benchmark for establishing quality improvement. This involves a review of current nursing quality outcomes; the implementation of a quality pathway for patients, and a review of outcome measures, examining established protocols and practice guidelines.

For any nurses and allied health professionals that would be prepared to share good practice with our colleagues around Europe and get involved with the QUIP programme please contact Tara Bartley, Lead Nurse for QUIP at Tara.Bartley@uhb.nhs.uk

Advanced Cardiothoracic Course

This year's **Advanced Cardiothoracic Course** was held on October 19th and 20th 2014 in Heartlands Hospital. Again this course was extremely well attended and feedback was excellent. We thank Sorin for their ongoing support for this course, and all the members of the faculty who took time to teach the delegates and share their experiences.

Cardiothoracic Forum

@ the SCTS Annual Meeting 2015 - Manchester

Wider nursing issues

Cecilia Anim has been elected as RCN President. Cecilia said: 'I am delighted to have been elected President of the RCN and it is a great honour to serve the RCN members. I'm immensely grateful for the support I've received. The nursing profession is going through tough times. I'm determined to be a vocal campaigner on behalf of the RCN members and will work tirelessly as President to secure a better future for nursing staff and their patients'. In her RCN election statement she said: 'I am proud to be a nurse with over thirty years experience of serving diverse communities – as a practising frontline nurse, steward, safety rep, and RCN Deputy President. In building a better future for nursing and for patients, I continue to be driven by the belief that a decent salary, job security and a working environment that does not compromise your safety or professional integrity is absolutely vital. The nursing family is facing increasingly tough times and I pledge to lead the RCN through these to restore pride and confidence in our profession. I promise to work tirelessly to contest government policies that assault the dignity of the hard-working and dedicated nursing staff across all sectors who deliver the best in patient care. I will work hard to protect special duty payments and will fight against any attempts to erode terms and conditions for the nursing family.'

We thank the past RCN President, Andrea Spyropoulos for all her support to the CT forum over the past two years and we look forward to meeting Cecilia, and extending our welcome and congratulations to her.

SCTS CT Forum Contacts

The SCTS CT Forum Facebook and Twitter page continue. The CT Forum is for all nurses and allied health professionals to belong to and I encourage you all to sign up to these pages and help us to communicate between all health care professionals working in the field of cardiothoracics, whether it be in outpatient departments, wards, intensive care, theatres or the community. We would like as many nurses and allied health professionals to join, to show that cardiothoracic health professionals have a voice and want to work together to improve the care provided for all patients.

The links for the pages are as follows, please pass these details on to as many nurses and allied health professionals that you all know and encourage everyone to participate.

Follow us at Twitter - @SCTS_CTForum

Join the Facebook Group - SCTS CT Forum

If any of your colleagues would like to become an associate member of the Society or would like to add their names to the SCTS Allied Health Professionals database so they can receive the emails that are sent out then please forward their name, address and title to me at Christina.Bannister@uhs.nhs.uk or chrissiebannister71@gmail.com or direct to Tilly Mitchell at tilly@scts.org

Chris Bannister

Nursing & Allied Health Professional Representative

Cardiothoracic Training
Core value

Cardiothoracic training has always been a core value for SCTS. The SCTS has valued and supported trainee members through the changing landscape with evolution of practice and EWTD. The aim always has been to offer maximum educational value and career guidance to the next generation cardiothoracic surgeons!

This has resulted in trainees meetings and the SCTS University. The young and vibrant SCTS Education has further offerings including the Ethicon fellowships and various educational opportunities to trainees, non-trainees and AHPs.

The SCTS/SAC Course Portfolio has recently been developed by the SCTS Tutors to optimize training opportunities. The portfolio is mapped to the entire ISCP curriculum. These courses are the first of their kind in the UK with every NTN trainee offered two structured courses every year. These courses will have simulation, live simulated operating and non technical skills along side structured core knowledge.

The SCTS/SAC Course Portfolio has recently been developed by the SCTS Tutors to optimize training opportunities. The portfolio is mapped to the entire ISCP curriculum.

Registration and accommodation will be provided free of charge for all NTN trainees with SCTS membership.

This giant step has been possible due to a substantial grant from Ethicon supported by Sorin.

Benefits of SCTS Trainee membership include:

- SCTS / SAC Curriculum aligned courses developed by the SCTS tutors, which includes 12 courses over 6 years including live operating simulation and non technical skills.
- Ethicon fellowship (£50,000 / fellowship)
- SCTS University
- SCTS meeting (concessionary rate)
- SCTS trainee website
- SCTS / SAC trainee meeting
- SCTS Executive/ SAC†membership for trainee lead
- SCTS / ACSA SCP / CT1 / ST1 course (free)
- SCTS team fellowship (free)
- SCTS leadership course for senior trainees (free)
- SCTS Mentorship advice / guidance from SAC Chair / SCTS Tutors / SCTS Dean
- SCTS abstract publication in peer-reviewed journal (2016 onwards)

We encourage all trainees to become SCTS members to allow them to take part in all of the above. The impact of offering a widened educational portfolio has resulted in an increase in the membership fees from £127 to £200.

We hope the trainees appreciate the value of SCTS by the educational offerings which they are benefitting from which is not available to any other specialty training. We believe that SCTS membership offers excellent value for money for NTNs.

Lung Cancer Surgeons Go Public

Richard D Page, Consultant Thoracic Surgeon, Liverpool Heart and Chest Hospital
SCTS Thoracic Audit Lead

In October of this year, individual consultant thoracic surgeons working in England have for the first time had details of their practices made available to the public.

The necessity for this followed a mandate from the Healthcare Quality Improvement Partnership (HQIP) acting on behalf of NHS Choices and NHS England, in line with the *"Everyone Counts: Planning for Patients"* initiative which has been introduced over recent years. One of the philosophies of this project is to make all aspects of medical treatment as transparent as possible to enable patients and their families to make more informed decisions about their care. The immediate focus has been on surgery and the outcomes for all surgical specialities, and more specifically for consultant surgeons. Clearly this has been led for many years by cardiac surgery and has been largely successful in terms of providing more detailed information about the types of operations and the outcomes for cardiac surgery, notwithstanding the negative aspects for individual surgeons themselves. In 2013 nine surgical specialities (cardiac, vascular, thyroid/endocrine, bariatric, orthopaedic, urological, colorectal, upper GI, and head/neck) published data on their commonest operations, with 30-day mortality, being the principle outcome measure. The data was produced from the National Audits being run by the individual surgical specialties, for example the National OG Cancer Audit run by the Association of Upper GI Surgeons, which focuses at the treatment of oesophageal and gastric cancer, and in particular therapeutic surgery for the disease. Only one medical speciality (interventional cardiology) was instructed to report its outcomes via HQIP in 2013.

Development

Despite a truly elephantine and prolonged gestation period which has lasted over ten years the SCTS thoracic surgical database was finally delivered into the world for the use of surgeons in April 2013 and so when the "Everyone Counts" agenda started we were led to understand that our speciality would not be required to publish thoracic outcomes until 2016. Unfortunately such a delay would have opened a significant gap between thoracic surgery and other specialities, which led to the SCTS being informed by HQIP that the timeline was being advanced by two years, i.e. that we were required to publish our thoracic outcomes in 2014. Thus in December 2013 and rather out of the blue, I received a letter from HQIP as thoracic audit lead for the SCTS, instructing me to work with colleagues running the National Lung Cancer Audit (NLCA, colloquially known as LUCADA) to publish outcomes on therapeutic primary lung cancer surgery for individual surgeons, in line with what was happening in the other surgical specialities.

Thankfully Mick Peake, consultant respiratory physician in Leicester and chairman of the NLCA steering committee and I managed to persuade HQIP of the wisdom of avoiding the publication of unadjusted post-operative mortality after lung cancer surgery for individual surgeons. There was no question in our minds that this would have directly led to higher-risk patients being denied surgery, with the immediate effect that significantly more patients would die from their cancers. Against the initial tide of the dogma (that individual-surgeon mortality was the only appropriate outcome to be published for surgeons) which was flowing against us from HQIP we managed to gain agreement that our publication would focus on:-

1. Therapeutic primary lung cancer surgical activity (i.e. all lobectomies, pneumonectomies, sub-lobar and complex resections) of individual surgeons and the 28 hospitals providing thoracic surgery in England
2. Overall raw 30 and 90-day mortality for the hospitals, but not for individual surgeons
3. The resection rate for lung cancer within the populations served by the surgical Units. More specifically we agreed to report on which surgeons were the core members of each of the lung cancer MDTs and by implication "their" resection rates.

The immediate focus has been on surgery and the outcomes for all surgical specialities, and more specifically for consultant surgeons

Differences

Over the last year I have been working with colleagues at the NLCA and SCTS thoracic audits leads in England to produce the information necessary for these outcomes. It was immediately clear that although the NLCA has been a very valuable project over the last few years in describing the prevalence of lung cancer and its management, it was never really conceived as a surgical database and was certainly never designed as a tool for producing data on individual surgical activity and outcomes. For some years I have been aware of significant and important differences in the data recorded by the NLCA and the SCTS Thoracic Register regarding the actual number of operations carried out, with generally more operations being done by surgeons than the NLCA credited them for. This difference is due to the way the data is collected between the NLCA and SCTS Register data streams. The former relies on entry of surgical procedures by the lung cancer MDTs, whereas the latter is directly available from the surgical Units. When the data were scrutinised at an individual patient level for this year's publication of outcomes it was clear that some patients were having lung cancer resections without the MDTs being able to capture all the surgical activity. This resulted in a disparity in not only the number of operations actually carried out by Units and

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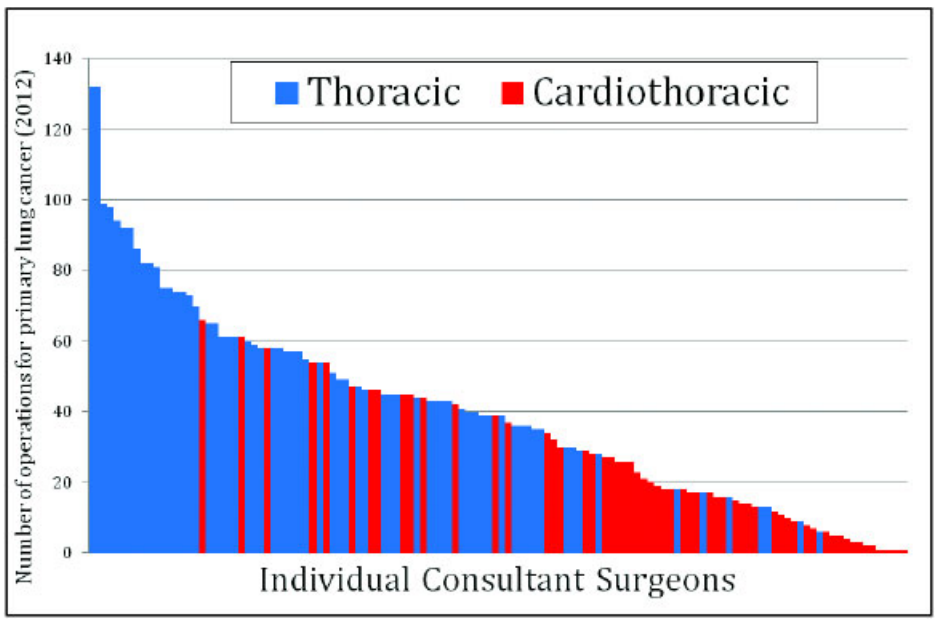
Lung Cancer Surgeons Go Public...continued

surgeons and those captured by the NLCA, but also the resulting lung cancer resection rates for the populations served by the Units. Despite this and having worked closely with SCTS audit leads and the NLCA over the last 10 months I am confident that the data for the publication is as accurate as it can be given the data sources available and the relatively short time frame we have had to work within.

The data for the publication is for patients undergoing therapeutic resections for primary lung cancer by English Thoracic Surgical Units in the calendar year 2012. Those Units who also treated patients living outside England were allowed to include these patients in their data as well.

There were 28 English Units providing thoracic surgery in 2012 with a total of 4952 lung cancer resections in all. The median number of resections per Unit was 138, with a range of 43 to 431. One hundred and twenty-two consultant surgeons carried out at least one therapeutic operation for lung cancer. The median number of operations per surgeon was 39, with a range of 1 to 132. The distribution of work amongst thoracic and cardiothoracic surgeons is shown in the chart.

The data is available on the SCTS website under the link www.scts.org/patients/thoracic/data.aspx



Things we have done well

There was a uniformly low 30 and 90-day mortality throughout the country for lung cancer resections in 2012. The average 30-day mortality was 2.2% with a range of 0% to 6.5%. The corresponding values for 90-day mortality were 4.5%, range 1.6% to 11.3%. No Units had outcomes outside the 3SD limits for post-operative deaths. As in previous SCTS publications this provides reassuring evidence that the standard of lung cancer surgery in England is very high and comparable with international standards.

Incidentally (although this hasn't been published) I am pleased to report that the outcomes for individual surgeons in terms of 30 and 90-day mortality were all within the 3SD limit also, i.e. no thoracic or cardiothoracic surgeons working in England had an inordinately high operative mortality for their lung cancer resection work in 2012.

Things we could do better

As described in previous NLCA publications there is a wide variation in the resection rate for lung cancer between surgical Units and the MDTs they serve throughout the country. For histologically confirmed non-small cell lung cancer the overall resection rate for patients developing the disease in 2012 was 24.6%, but ranged from 14.2% to 34.4% for the populations served by the 28 English Surgical Units. For the 152 individual lung cancer MDTs in England the range was 10.1% to 41.4%. Although the reasons for these variations are complex and multifactorial and are clearly the responsibility of the whole lung cancer team rather than just thoracic surgeons, it behoves surgeons to:-

1. Attend the lung cancer MDTs in line with their responsibilities as core members to give appropriate advice to the lung cancer team in managing patients with suspected or proven lung cancer
2. See as many patients as possible who may be candidates for lung cancer surgery in the surgical clinics, and
3. Work with all colleagues to ensure that adequate facilities are available in the surgical Units for patients to have their surgery in a timely manner

Throughout the last year leading towards the HQIP publication it was gratifying that a pragmatic and positive working relationship between the SCTS and NLCA emerged which augers well for the future. Nevertheless it is clear to me that the NLCA database in its current format and with the way the data is entered is not an adequate tool to respond to the demands of the increasing scrutiny that will presumably continue to affect thoracic surgeons not only in England but also in other parts of the UK and Ireland. It is therefore crucial that thoracic surgeons themselves continue to take responsibility for collecting accurate and detailed data on their work and contribute universally to the SCTS thoracic database.

And finally, despite having enjoyed my involvement in thoracic audit for the SCTS over the last decade (and especially working with SCTS thoracic audit leads) I am pleased to have handed over this responsibility to Doug West and other SCTS colleagues. I wish them the best of fortune for their endeavours in the future.

Significant Developments in Law and Ethics - An Update for 2014

Michael Devlin
Head of Professional Standards and Liaison at the MDU

In medical law and ethics things rarely stand still for too long. Thus there have been some important developments that surgeons and other healthcare professionals should be aware of.

Wilful neglect and ill-treatment

The events of Mid Staffordshire led to the publication of a detailed report by Robert Francis QC in 2013[1]. Subsequently, the Berwick Report[2] made a number of positive recommendations on building a culture of safety in UK. Among these was a recommendation that a criminal offence of wilful neglect or ill-treatment be created to fill a perceived gap in the law.

You may well wonder what the gap was. Offences of wilful neglect or ill-treatment currently exist in statutes governing mental health, mental capacity and the welfare of children. This is not entirely unexpected, as these three groups in society are potentially very vulnerable, so the law protects them.

But other groups in society are not especially vulnerable and are able to speak out if they think they have been subjected to mistreatment. However, the Government accepted this particular recommendation, promising to legislate as soon as parliamentary time allowed.

Following a short consultation, the Government response was published in June 2014[3] and shortly after that amendments were tabled to the Criminal Justice and Courts Bill[4]. Clauses 17 and 18 of the Bill introduce new offences of wilful neglect and ill-treatment for individuals and provider institutions respectively.

At the time of writing, it is proposed that the threshold for criminal liability is higher for the provider, where there has to be a gross breach of duty, than for individuals. This difference in threshold for providers and individuals may change as the Bill completes its legislative process. As it currently stands, it appears inconsistent with the Department of Health's stated position which is that the new offence would only apply in "clear cases" of wilful neglect or ill-treatment which, in principle, should be the same whether the defendant is an individual or an organisation.

The MDU continues to work to try and ensure the new offence is fair to doctors, but it is likely that the new offence will make it into law later this year.

In practical terms surgeons and other clinicians should be aware of the potential for criminal investigation arising from the care of patients they have treated

In practical terms surgeons and other clinicians should be aware of the potential for criminal investigation arising from the care of patients they have treated, and some basic rules should be followed:

1 If you are interviewed by the police under caution, contact your medical defence organisation straight away – it is unwise to comment without the benefit of legal advice.

2 Do not alter the clinical records after the event, even if you can remember additional details of the treatment or assessment of the patient. If necessary, your solicitor will be able to help you make any relevant points to the investigators while protecting your interests.

3 Ensure your Trust is aware of the investigation, although it is likely it will be. It is not unusual for the Trust to restrict or even suspend your practice while the investigation is ongoing.

4 Take advice from your medical defence organisation on whether proceedings have reached the point that requires notification to the GMC (typically this will be if you are charged with a criminal offence)[5].

It is also worth reflecting on how allegations of wilful neglect or ill-treatment might arise. The importance of good, clear communication with patients and those close to them cannot be emphasised enough. It is possible that some allegations may result from a simple misunderstanding. For example, a recommendation by an MDT that a particular patient was unsuitable for coronary artery surgery, who subsequently dies before alternative treatment options can be fully considered, could give rise to an allegation of wilful neglect.

Statutory Duty of Candour

The Department of Health consulted earlier this year on a proposed statutory duty of candour (which would take effect through CQC registration regulations in England). The response was published in July 2014[6]. The statutory duty is in addition to the ethical obligation on doctors and other health professionals to tell patients when something goes wrong and harms them. The ethical obligation applies in all situations, not simply those where the patient has suffered "significant" harm - which is the statutory duty's threshold - and is a composite category of moderate harm (or worse) and prolonged psychiatric harm.

The statutory duty will apply to the healthcare organisation caring for the patient, not the individual clinician, and were due to be introduced in October 2014 for NHS Trusts, and by April 2015 for other providers of care, such as GPs.

Although the duty of candour applies to organisations, inevitably doctors will be involved by ensuring that relevant hospital managers receive reports about patient safety incidents and by following their own ethical obligation to tell the patient what has happened, to put it right if possible and to offer an apology where appropriate.

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Significant Developments in Law and Ethics

An Update for 2014 *continued*

The vital thing from the individual surgeon's perspective is to follow the reporting procedures your Trust has in place, which will probably be the same as those used for clinical governance purposes.

To add to an already confusing picture of what threshold applies to whom and when, the contractual duty of candour, introduced in 2013, also has its own threshold. This is broadly the same as the statutory duty. A summary of the contractual duty, which is complex in its operation, can be found here[7].

Medical Innovation Bill

The Bill is currently going through parliament, having been introduced in the Lords[8]. In essence, its stated aim is to encourage responsible innovation in medical treatment and it developed from the idea that doctors may be deterred from innovating because of the threat of litigation.

The MDU regularly receives calls from members who are considering innovative treatment. Our advice is that there should be no reason to fear the consequences of doing so provided:

- There are appropriate safeguards in place – that the doctor can demonstrate that there are good reasons to depart from conventional practice in the patient's best interests, and
- The patient fully understands what is proposed and why the clinician considers it is in their best interests, and that weighing this in the balance, they are able to make an informed choice as to whether to accept the innovative treatment.
- The MDU does not have any evidence that doctors are deterred from innovating responsibly and our belief is that the Bill is unnecessary.

Competition and Markets Authority (CMA)

The CMA published its final report into the private healthcare market investigation in April 2014[9]. The findings have been implemented in a Final Order, and Parts 3 and 4 has various provisions relevant to those practising in the private healthcare sector[10].

Some of the findings relate to the structure of private hospital operators, but others will have implications for individual doctors working in the private sector. One of the remedies is a restriction or ban on certain benefits and incentive schemes provided by private hospitals operators to clinicians. Another is a combination of measures to improve public availability of information on consultant fees and of information on the performance of consultants and private hospitals.

Following GMC guidance on conflicts of interests and financial arrangements[11] should ensure that an individual's practice will not fall foul of CMA requirements.

Michael Devlin
Head of Professional Standards and Liaison at the MDU
July 2014

References

1 Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery office. Available at www.midstaffspublicinquiry.com/

2 National Advisory Group on the Safety of Patients in England. (2013) A promise to learn – a commitment to act: improving the safety of patients in England. London: The Stationery Office. Available at: https://www.gov.uk/government/publications/berwick-review-into-patient-safety

3 Department of Health. (2014) New offences of ill-treatment or wilful neglect: Government response to consultation. London: The Stationery Office. Available at: https://www.gov.uk/government/consultations/ill-treatment-or-wilful-neglect-in-health-and-social-care

4 The Bill and its progress can be viewed online at: http://services.parliament.uk/bills/2013-14/criminaljusticeandcourts.html

5 See GMC. (2013) Reporting criminal and regulatory proceedings within and outside the UK. London: GMC. Available at www.gmc-uk.org/guidance/ethical_guidance/ 21184.asp

6 Department of Health. (2014) Requirements for registration with the Care Quality Commission: Response to consultations of fundamental standards, the Duty of Candour and the fit and proper persons requirement for directors. London: Department of Health. Available at: https://www.gov.uk/government/consultations/fundamental-standards-for-health-and-social-care-providers

7 Devlin, M. (2013) What the contractual duty of candour means for doctors. London: MDU. Available at: www.themdu.com/guidance-and-advice/latest-updates-and-advice/what-the-contractual-duty-of-candour-means-for-doctors

8 The Bill can be seen and its progress followed at: http://services.parliament.uk/bills/201415/medicalinnovation.html

9 Competition and Markets Authority. (2014) Private healthcare market investigation: Final report. London: The Stationery Office. Available at: https://www.gov.uk/cma-cases/private-healthcare-market-investigation

10 Private Healthcare Market Investigation Order 2014, available at: https://assets.digital.cabinet-office.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

11 GMC. (2013) Financial and commercial arrangements and conflicts of interest. London: GMC. Available at: www.gmc-uk.org/guidance/ethical_ guidance/21161.asp

Heart Research UK
Grants Programme 2015

Helen Wilson
Senior Research Officer

New Closing Date for Applications

Dear Colleague

I am pleased to announce details of the Heart Research UK medical grants programme for 2015 which includes the following: -

Novel and Emerging Technologies Grant (Up to £250,000)

Outline applications accepted 1 December 2014 - 6 January 2015

Deadline for full applications 1pm, 1 April 2015

PLEASE NOTE THE NEW, **EARLIER** CLOSING DATES

Translational Research Project Grants (Up to £150,000 each)

Deadline for applications 1pm, 1 June 2015

PLEASE NOTE THE NEW, **LATER** CLOSING DATE

Please see the HRUK website for more information and details of how to apply www.heartresearch.org.uk

I would be very grateful if you would display the below poster in your department and disseminate this information as widely as possible to your colleagues.

Grants Programme Announcement Poster

Thank you for your help and please let me know if you would like any more information.

Kind regards

Helen

Helen Wilson (Senior Research Officer)

Heart Research UK
Tel 0113 234 7474
grants@heartresearch.org.uk

SCTS Tutors' Report

We have had an exciting six months with various progressive developments. The SCTS Education Course on Essentials Skills in Cardiothoracic Surgery was developed and is held in the Royal College of Surgeons of Edinburgh. The Portfolio courses running in 2015 have the programme and learning objectives finalised. The Courses will have the heavy simulation and small group delivery as we stated in our previous report.

Mr Rathinam represents the tutors and SCTS in the JCST Simulation group. The SCTS **Introduction to Specialty Training in CT Surgery ISTiCTS** (Boot camp) and the simulation aspect of proposed training programme was discussed in the last meeting. The new chair of JCST Mr Bill Alum was impressed by our programme and attended the ISTiCTS Course in Gloucester in Nov 2014.The ISTiCS has evolved and developed based on last years feedback. The ST1s were not invited and will be invited when they enter ST3.

The portfolio of courses is evaluated according to the SCTS Education standards with a standing invitation to the SAC chair to visit our courses for quality control. The Education secretaries will discuss wider external validation with the SAC.

A registry of all NTNs has been developed so that they can be intimated at adequate notice about the various courses relevant to their training year.

We as always would like to take this opportunity to thank all the course directors and faculty members, who have provided their time, wisdom and enthusiasm. It has been much appreciated by the trainees and without which it would have been impossible to deliver these courses. If anyone else is interested in teaching on the portfolio of courses in the future, we would be grateful if you could contact us (narainmoorjani@hotmail.com or sridhar_rathinam@yahoo.co.uk), as we would value your support.

We are also greatly indebted to our industry partners, especially Ethicon and Sorin, for their organisational and financial support.

Narain Moorjani, SCTS Cardiac Surgery Tutor

SridharRathinam, SCTS Thoracic Surgery Tutor

Course Calendar

Core Cardiac Surgery
1-3, December 2014, Sorin National Wet-lab Centre Gloucester
Course Directors: Mr C Lloyd, Mr J Zacharias and Mr N Moorjani

Essentials Skills in Cardiothoracic Surgery
16-17, December 2014, Royal College of Surgeons of Edinburgh
Course Directors: Ms E Belcher and Mr J Nowell

Intermediate Viva Course
21-22 January 2015 J&J Campus, Wokingham,
Course Directors:Mr D Whitaker / Mr K Lau / Mr N Moorjani / Mr S Rathinam

Cardiothoracic Subspecialty Course
9-12 February 2015 Ethicon Centre Hamburg
Course Directors: Mr N Moorjani, Mr S Rathinam, Mr E Akowuah and Mr M Kalkat

Revision and Viva Course for the FRCS (CTh)
2- 5 March 2014 J&J Campus, Wokingham,
Course Directors: Mr M Baghai, Mr D West, Mr N Moorjani and Mr S Rathinam,

Cardiothoracic Intensive Therapy & Surgical Access Course
20-22 May 2015 Ethicon Centre Hamburg
Course Directors: Mr J Dunning, Mr N Roberts, and Dr C Moore

Core Thoracic Surgery
22-24 June 2015 (TBC) MATTUS Centre Surrey
Course Directors: Mr T Routledge and Mr S Rathinam

SCTS Ionescu University & ACTA Academy

and

ACTA/SCTS Joint Annual Meeting & Cardiothoracic Forum

Wednesday 25th March to Friday 27th March 2015

MANCHESTER CENTRAL, MANCHESTER UK

Topics

- Innovations in Thoracic Surgery
- Collaborative Working
- Controversies in Thoracic Surgery
- Minimally Invasive Cardiac Surgery
- Ischaemic Mitral Valve Surgery
- Coronary Artery Surgery
- Cardiothoracic Forum
- ITU Management
- Organ Protection
- Blood Management
- Aortic Surgery
- Peroperative TOE
- Transcatheter Valve Implantation
- Tricuspid Valve Surgery
- Outcomes in Cardiothoracic Surgery
- Surgery of the Elderly
- Training and Service Provision
- Understanding Vein Graft Patency
- Temporary Ventricular Support on the ITU
- Management of a High Risk Median Sternotomy
- Pleural Disease Management
- Aortic Valve Repair
- Cerebral Monitoring and MEPs
- New Heart Valve Designs
- Advanced Heart & Lung Failure
- Innovation in an Era of Clinician Specific Data
- Management of Right Ventricular Dysfunction
- Congenital Heart Surgery

International Guest Speakers

Michael Acker	Philadelphia
Ottavio Alfieri	Milan
Manuel Antunes	Coimbra
Alain Berrebi	Paris
Duke Cameron	Baltimore
Andre Denault	Montreal
Gebrine El Khoury	Brussels
John Elefteriades	New Haven
Joerg Ender	Leipzig
Pierre-Emmanuel Falcoz	Strasbourg
Mattia Glauber	Massa
Klaus Görlinger	Munich
Hilary Grocott	Winnipeg
Fabio Guarracino	Pisa
Philippe Kolh	Liege
Massimo Lemma	Milan
Gilbert Massard	Strasbourg
David Mazer	Toronto
Dianna Milewicz	Houston
D Craig Miller	Stanford
Frederick Mohr	Leipzig
Patrick Perier	Bad Neustadt
Albert Perrino	New Haven
Steffen Pfeiffer	Nuremburg
Scott Reeves	Charleston
Colin Royse	Melbourne
Mark Ruel	Ottawa
Joe Sabik	Cleveland
Hanneke Takkenberg	Rotterdam
Alper Toker	Istanbul
Santi Trimarchi	Milan
Alec Vahanian	Paris
Dirk Van Raemdonck	Leuven

For further information, please visit
www.scts.org or www.acta.org
or contact Isabelle Ferner,
Society Administrator
& Conference Organiser
at sctsadmin@scts.org
or +44 (0) 20 7869 6893.

MANCHESTER CENTRAL
Manchester
2015
25-27 MARCH

Announcements

Professor Sir Bruce Keogh

I am sorry to inform colleagues that Professor Sir Bruce Keogh has decided to resign from the Society. After 7 years away from cardiac surgery and an extremely hectic schedule, Sir Bruce is rationalizing his commitments.

Sir Bruce was SCTS secretary from 1998 to 2003 and President 2006 – 08. He was a superb leader of our specialty establishing the adult cardiac surgical database and leading us to publish our individual outcomes in 2005. Although he will still be a part of our community, he is a great loss to the specialty not only in the UK just but also a great loss to the European and American Associations where he has also made major contributions.

Simon Kendall

Subscriptions

Dear all

Please note that your SCTS Annual subscriptions will leave your bank account on or around 1st January 2015.† Please find a list of current subscription rates below and I am delighted to announce that once again we have frozen subscriptions for most categories and hope that you feel this represents value for money.

As always, I would welcome any suggestions and comments on how the service provided by the Society office can be improved and I would like to take this opportunity to wish you all a happy and health festive season and new year.

Annual Subscription 2015

Consultant	£302.50
Trainee	£200*
Associate	£30.00
Associate Specialist*	N/A
Overseas	£127.00
Life Overseas	N/A
JTCVS	£150

*subscription includes complimentary registration to a broad education programme overseen by SCTS Education.

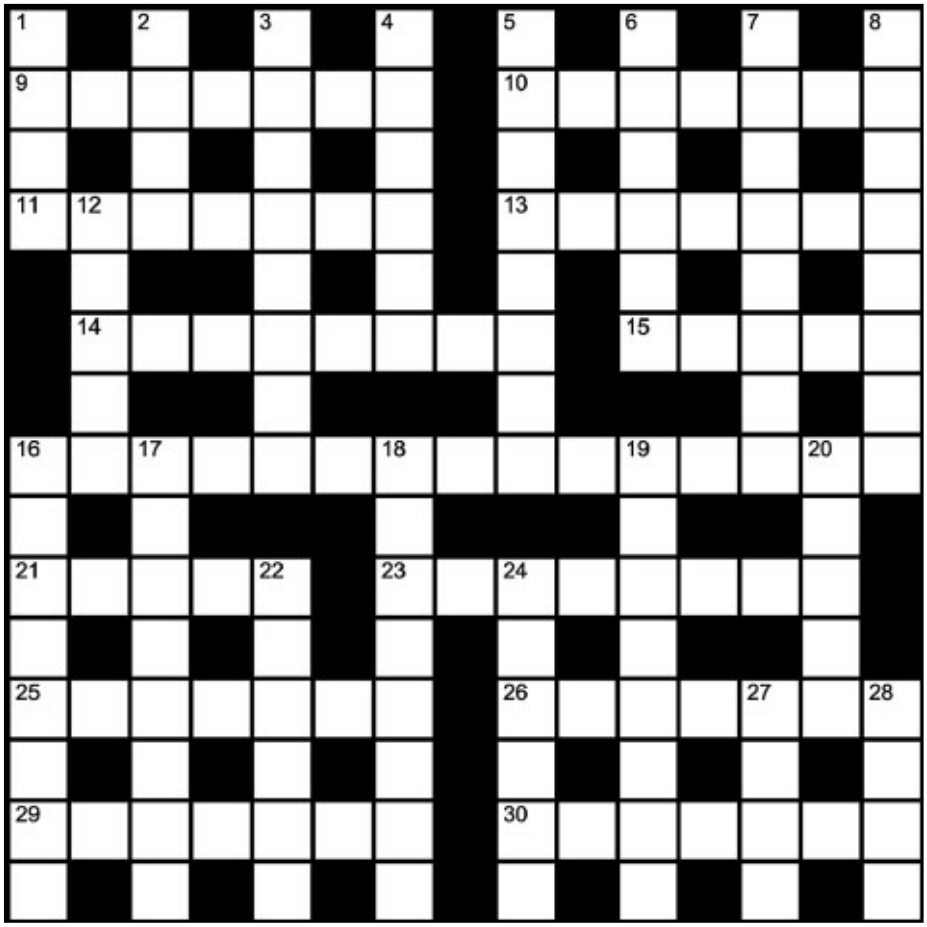
Best wishes

Isabelle

Isabelle Ferner
Society Administrator & Conference Organiser

the crossword

by Sam Nashef



Last issue's solution

Send your solution by 30 July 2015 to:

Sam Nashef, Papworth Hospital, Cambridge CB23 3RE or fax to 01480 364744

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

Congratulations to the July Crossword Winner

Jonathan Hyde

Across

9 River, long river, may turn 2,6 (7)
10 Born extremely deaf, starts to use letters as necessary (7)
11 Revolutionary dislike for returning fast runner (7)
13 Do popes alter their position on contraception? (7)
14 He wrote of daintily clad bird (8)
15 I find nothing in cracked jar of wine (5)
16/21 All very racy, the old set novel (4,11,5)
23 Bananas not all attractive (8)
25 In future may be passionate (7)
26 Chemical cliché (7)
29 Work with Carmen, say, by the other 14 (7)
30 No hope for these two in Jamaica (7)

Down

1 Kept in the picture - it's a long story (4)
2/6 16 21 willing custodian (10)
3 Mother's leaving choirmaster to prepare speech (8)
4 Harp on about being a deprived child (6)
5 Flip between Southampton and Cowes (8)
6 See 2
7 Clue for horse not on the mainland (8)
8 Happy music's smart gear (8)
12 Girl - child at heart (5)
16 Sweet pill - polo mint (8)
17 Fans vote in rising tennis player (8)
18 Perhaps the least of what they do is run (8)
19 Answer with rare stamp on square envelopes (8)
20 Your leader lied atrociously, so give up (5)
22 Strip and escape - that's heartless (6)
24 Not one reason why murder investigation cannot proceed (6)
27 I governed Persia once (4)
28 Sounds like you paddle for money (4)