WHSSC Joint Committee Meeting held in public

Friday 28 June 2019 at 14:00 Hours

Health and Care Research Wales - Castlebridge 4, 19-15
Cowbridge Rd East, Cardiff CF11 9AB

Item	Lead	Paper/ Oral	Time
1. Preliminary Matters			
1.1 Welcome, Introductions and Apologies - To open the meeting with any new introductions and record any apologies for the meeting.	Chair	Oral	14:00 - 14:05
1.2 Declarations of Interest - Members must declare if they have any personal, business or pecuniary interests, direct or indirect, in any contract, proposed contract, or other matter that is the subject of consideration on any item on the agenda for the meeting.	Chair	Oral	
2. Items for Consideration and/or Decision			
2.1 Thoracic Surgery Update - Note the initial advice from the two provider Medical Directors - Note the detailed workforce planning and consultation responses. - Note the advice of external experts. - Note the comments from the provider medical directors. - Note the comments of the representative of the All Wales Cancer Network Site Specific Group for Lung Cancer. - Support the recommendations regarding the future consultant workforce model for thoracic surgery and emergency cover for the MTC subject to review prior to the single site thoracic surgical centre opening - Support the recommendations to go forward to the six affected health boards and that they be asked to confirm their unconditional approval for a single adult thoracic surgery centre based in Morriston Hospital, Swansea. **Contact:** Luke.Archard@wales.nhs.uk	Director of Planning	Att.	14:05 – 15:00

3. Concluding Business			
3.1 Any Other Business	Chair	Oral	
3.2 Date of next meeting (Scheduled) - 23 July 2019, 13:30 – 17:00 - Education Centre, University Hospital Llandough, Penlan Road, Penarth, CF64 2XX	Chair	Oral	

		Agenda Item	2.1
Meeting Title	**Joint Committee**	Meeting Date	28/06/2019
Report Title	Thoracic Surgery Workforce Planning		
Author (Job title)	Director of Planning		
Executive Lead (Job title)	Managing Director	Public / In Committee	Public

Purpose	1. To re-confirm the advice from the provider Medical Directors and to provide the Joint Committee with further information regarding the thoracic surgery consultant workforce arrangements required for a single service located at Morriston Hospital, Swansea and the cover arrangements for the Major Trauma Centre (MTC). This will include: • Detail regarding the anticipated demand for thoracic surgery in south Wales, this includes out-patient and surgical activity and allows for the planned 20% increase in activity; • Expert advice on the level of activity required to maintain consultant thoracic surgeons' skills; • Development of indicative job plans for consultant thoracic surgeons to inform an assessment of the appropriate number of consultants; • Detailed costings for any proposed increase in consultant thoracic surgeons above the original WHSSC recommended level of six consultants; • Clarity on the role of trauma surgeons in the immediate management of emergency trauma patients and the requirement for input from thoracic surgeons (e.g. telephone advice or on site input); and • Clarity on the interface of thoracic surgeons in managing trauma patients with other specialties (e.g. rib fixation with orthopaedic surgeons). 2. To make recommendations regarding the future consultant workforce model and emergency cover of the MTC.

RATIFY	APPROVE	SUPPORT	ASSURE	INFORM
☐	☐	X	☐	X

Sub Group /Committee	Joint Committee	Meeting Date	28/06/2019
Recommendation(s)	Members are asked to: • **Note** the initial advice from the two provider Medical Directors • **Note** the detailed workforce planning and consultation responses. • **Note** the advice of external experts. • **Note** the comments from the provider medical directors. • **Note** the comments of the representative of the All Wales Cancer Network Site Specific Group for Lung Cancer. • **Support** the recommendations regarding the future consultant workforce model for thoracic surgery and emergency cover for the MTC subject to review prior to the single site thoracic surgical centre opening • **Support** the recommendations to go forward to the six affected health boards and that they be asked to confirm their unconditional approval for a single adult thoracic surgery centre based in Morriston Hospital, Swansea.		

Considerations within the report (tick as appropriate)

	YES	NO		YES	NO		YES	NO
Strategic Objective(s)	✓		Link to Integrated Commissioning Plan	✓		Health and Care Standards	✓	
Principles of Prudent Healthcare	✓		Institute for HealthCare Improvement Triple Aim	✓		Quality, Safety & Patient Experience	✓	
Resources Implications	✓		Risk and Assurance	✓		Evidence Base	✓	
Equality and Diversity		✓	Population Health	✓		Legal Implications	✓	

1.0 SITUATION

In November 2018, the six affected health boards considered the report on the outcome of the public consultation and the recommendations for the future service model for adult thoracic surgery in south east Wales, west Wales and south Powys. Each health board approved each of the three recommendations on the future service model (subject to a requirement for further assurance as outlined below). These recommendations were:

- Thoracic surgery services for the population of south east Wales, west Wales and south Powys are delivered from a single site;
- The location of that single site as being Morriston Hospital conditional upon the detailed workforce model and medical rotas to provide the 24/7 thoracic surgery cover to the MTC being completed and signed-off by WHSSC within 6 months; and
- Mitigating actions set out in this document [the consultation report] to be delivered in line with the implementation of the service change.

In addition to the requirement within the second recommendation to agree the rota for the MTC within 6 months, some Boards set out other areas on which they required further assurance for their Community Health Councils (CHCs) for final unconditional approval to be confirmed. This included issues such as parking and transport, the availability of family accommodation on the Morriston site, and the wider care pathway for thoracic patients. It was also noted that South Glamorgan CHC (formerly Cardiff and Vale CHC) however was unable to support the proposal and required further assurance before this was possible.

In January 2019, Joint Committee agreed the governance arrangements for implementation of the recommendations. WHSSC would develop the commissioning plan; SBUHB would establish the implementation project board which would report via the SBUHB Board through WHSSC to Joint Committee.

It was also confirmed that WHSSC would bring a further report to Joint Committee in May 2019 to include the following:

- A workforce plan to provide thoracic surgical cover to the MTC, led by the Medical Directors of SBUHB and CVUHB;
- Lessons learned from the experience of undertaking the public consultation; and
- An outline of actions to address the additional assurances required by the affected health boards.

It was anticipated this report would then go forward to the next meeting of each affected health board to seek their unconditional approval for the

recommendation for a single thoracic surgery centre located at Morriston Hospital, Swansea.

At its meeting held in May 2019, the Joint Committee received a paper that:

- Outlined the latest information regarding the thoracic surgery cover arrangements for the MTC, including the workforce arrangements suggested by the medical directors of SBUHB and CVUHB *(Proposal attached as Appendix A for ease of reference)*, and provide a commissioning assessment of those arrangements;
- Provided assurance on the arrangements for addressing the further issues raised by the affected health boards as part of their conditional approval of the recommendation for a single adult thoracic surgery centre based in Morriston Hospital, Swansea *(Table attached as Appendix B for ease of reference)*;
- Highlighted the key lessons learned from the review of the conduct of the engagement exercise and public consultation *(Report attached as Appendix C for ease of reference)*;
- Noted the development of the thoracic surgery commissioning plan *(Plan attached as Appendix D for ease of reference)*;
- Noted the implementation project has been established by SBUHB; and
- Sought support from Joint Committee for the recommendations to go forward to the six affected health boards and that they be asked to confirm their unconditional approval for a single adult thoracic surgery centre based in Morriston Hospital, Swansea.

After careful consideration and discussion Members of the Joint Committee:

- Requested Dr Sian Lewis (and the WHSS Team) bring a WHSSC commissioning proposal back to the Joint Committee by the end of June 2019 that would take into consideration a number of matters and some uncertainties identified in the paper and during the meeting, related to workforce arrangements that had been developed to provide thoracic surgical cover from Morriston Hospital, Swansea, for the MTC in UHW, Cardiff;
- Noted and received assurance that arrangements are in place to address the further issues raised by the affected health boards in November 2018;
- Supported the recommendations arising from the assessment of lessons learned from the engagement exercise and public consultation;
- Noted the development of the thoracic surgery commissioning plan; and
- Noted the implementation project led by SBUHB has commenced with project board and stakeholder meetings already held.

The final recommendation set out in the paper was postponed.

The indicative scope of work for the WHSS Team included:

- Providing detail regarding the anticipated demand for thoracic surgery in south Wales, this would include out-patient and surgical activity and allow for the planned 20% increase in activity;
- Expert advice on the level of activity required to maintain consultant thoracic surgeons' skills;
- Development of indicative job plans for consultant thoracic surgeons to inform an assessment of the appropriate number of consultants;
- Detailed costings for any proposed increase in consultant thoracic surgeons above the original WHSSC recommended level of six consultants;
- Clarity on the role of trauma surgeons in the immediate management of emergency trauma patients and the requirement for input from thoracic surgeons (e.g. telephone advice or on site input); and
- Clarity on the interface of thoracic surgeons in managing trauma patients with other specialties (e.g. rib fixation with orthopaedic surgeons).

Following the May 2019 meeting, the Chair of WHSSC wrote to the Chairs and Board Secretaries of the six affected health boards to explain what had happened at the meeting and the next steps, to enable them to update their respective Boards at their May 2019 meetings.

2.0 BACKGROUND

To provide the Joint Committee with the additional information and clarification which would allow them to make a decision regarding future consultant work force planning for thoracic surgery the WHSS Team undertook the following work:

- Development of a detailed workforce planning document which included the external expert advice previously provided during the service review (including the 2016 RCS review), the service specification, current activity data and trends as well as the projected activity and local expert advice provided via the implementation group (Appendix E)
- Testing of the assumptions in the documents through a consultation process involving local thoracic surgeons, the Welsh Medical Directors Peer Group, the Major Trauma Network Clinical Lead, and members of the Thoracic Surgery Implementation Board (Appendix F)
- Holding 1:1 teleconferences with the medical directors of the provider health boards who developed the original paper, which made a recommendation of 8 consultant surgeons, to understand the wider strategic issues from the provider perspective.
- Holding a tele-conference of external experts (Members of the Society of Cardiothoracic Surgeons of the UK and Ireland Thoracic Committee and Executive Committee and the NHSE National Clinical Director for Trauma)

to test the workload assumptions and understand the requirements to maintain thoracic surgical expertise and the interface with trauma surgeons.
- Holding a video conference with a representative of the All Wales Cancer Network Site Specific Group for Lung Cancer to understand broader service developments and requirements which might affect thoracic surgery services in Wales in the future.

3.0 ASSESSMENT

The workforce planning document was developed by the WHSS Team (appendix E). The document was based on information derived from:

- Findings from the RCS Invited Review 2016,
- The WHSSC Service Specification for Thoracic Surgery
- The NHS England Service Specification for Thoracic Surgery
- Current activity levels of the two units plus 20% additional workload
- Information provided by the two clinical summits held in March and May 2019 by the Thoracic Surgery Implementation Board.
- Comparison with other thoracic surgical centres in the UK.

The key conclusions were that:

- the number of thoracic surgeons required for the workload is around 5.5 to 6.2 WTE consultants depending upon the exact job plan and the allocation of Direct Clinical Care (DCC) and Supporting Professional activities sessions.
- the amount of operating time is the crucial driver and that for the predicted activity (outturn plus 20%) 6.25 lists will be required every week. To enable every surgeon to have one full operating list this means that around 6 surgeons will be required.
- Given the low probability of the surgeon being required to attend the MTC and the thoracic surgery centre at exactly the same time that there should be one on-call rota.

3.1 Initial advice from the provider Medical Directors

The work of the provider medical directors identified that 8 consultant surgeons were needed to provide two 1:4 rotas and ensure support for the MTC.

This was based on the following

- There is no existing on-call rota and therefore all out-of-hours workload will be in addition to current workload.
- There is a requirement to provide timely input across two geographically separate sites in order to provide safe and effective cover to the MTC as well as improve the outcomes in Thoracic Surgery.

- Taking annual leave and study leave into account, the prospective cover for 5 consultants equates to a 1 in 4 rota, which is not sufficiently robust to deal with sickness or unexpected absence

3.2 Findings from consultation process

Comments to the consultation document were received from:

- 3 Medical Directors
- 1 Consultant Respiratory Physician
- 2 Consultant Thoracic Surgeons
- Wales Trauma Network
- 1 Consultant Medical Oncologist
- Wales Cancer Network
- 1 Consultant Cardiothoracic Surgeon
- 2 Health Board Chief Executives

The following key themes were raised:

Theme	WHSS Team Response
The predicted increase in workload of 20% is likely to be an underestimate.	We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We therefore suggest a further comprehensive assessment 6 months pre-implementation as well as ongoing review as normal part of WHSSC processes. This will allow additional recruitment if needed.
There is insufficient workload at the UHW site to warrant a full time thoracic surgeon being placed there.	This was agreed through consultation. However the interim model suggested would allow further evaluation of the demand and if needed reconsideration by boards in the future.
The interim arrangement of employing a locum surgeon for 6-12 months to support the opening of the MTC was welcomed. It was felt this would allow a 24/7 rota from April 2020, training and development capacity for trauma surgeons, time for an MTC workload assessment and development of cross site support.	This is a key element in future planning and addresses both the short term issue of establishment of the MTC in April 2010 and well as allowing an evidenced based approach to future workforce modelling for the new single centre due to open in 2 years' time. Following consultation the recommendation has been amended to 12 months rather than 6 months.

Planning around 'long operating days' of 3 sessions was not optimal.	The RCS review recommended this as the optimal model for efficiency. It is recognised however that different models currently operate across the two centres and so it is recommended that this is revisited during implementation.
Six surgeons is not sufficient to provide 2 rotas and 2 rotas are necessary to cover both the MTC and the thoracic centre in Morriston because of the distance to travel and because of the risk of concurrent clinical emergencies.	We have taken expert advice on this which tells us that the new model should not attempt to operate two rotas. The expert advice was that this is neither desirable nor necessary as the requirement for thoracic surgeons to attend the MTC in an emergency is rare and other skilled trained professionals can deal with intrathoracic bleeding. The advice also said that recruiting to a 2 rota model would in their opinion be difficult.
Various comments on the way the number of sessions have been calculated.	Whilst there are differing opinions on the methodology used the calculations benchmark slightly above that for other UK centres and are therefore likely to be meaningful. Additionally the advice from the expert panel confirmed that with the current (+ 20%) activity, 6 surgeons is sufficient.
Factual inaccuracies or omissions	These have been noted and the changes have been attached as an addendum to the original paper. See appendix E

3.3 Expert advice and analysis of the WHSSC workforce planning document:

- **Provider medical directors** raised concern regarding the conclusion that approximately 6 surgeons would be sufficient for the service. They felt that there was insufficient capacity to meet changes in future demand (e.g. the single cancer pathway of future lung cancer screening) or to allow the service to manage unplanned vacancies. In addition it would make it more difficult to recruit into what they felt was a 'shortage speciality'. They also emphasised the need for the workforce to be able to expand to include service developments such as academic appointments. They were however supportive of the proposal to provide thoracic surgery

cover to the MTC from April 2020 which would allow both the delivery of a 24/7 on-call rota when the unit opens and the capacity to provide training to trauma and orthopaedic teams. They agreed that it allowed time to more fully assess the volume and intensity of the emergency thoracic trauma work.

- **Expert external advisors.** Full detail of the discussion and names and roles of the external advisors can be found in Appendix G. Below are the key points from the discussion:

    - **Clarity on the interface of thoracic surgeons in the immediate management of trauma patients:** There was consensus amongst the experts (including the NHS England National Clinical Director for Trauma) that trauma surgeons are the first line of support for patients with thoracic trauma and that both cardiac and thoracic surgeons are competent to stop intra-thoracic bleeding. The Chair of the Specialty Advisory Committee (SAC) for Cardiothoracic Surgery to the Joint Committee on Surgical Training (JCST) noted that the current training programme means that both cardiac and thoracic trainees have the competency to manage emergency thoracic trauma and all existing consultants should have the competency. If they do not then they should be offered the opportunity of further training. The National Clinical Director for Trauma noted that in his experience cover for thoracic trauma could be provided by either cardiac or thoracic surgeons.

    - **Clarity on the interface of trauma surgeons in managing trauma patients with other specialties:** There was a common view (shared by the National Clinical Director for Trauma) that rib fixation needed to be carried out by surgeons competent in this technique which could be either orthopaedic or thoracic surgeons. It was noted that patients with poly-trauma looked after at the MTC should have regular access to onsite thoracic surgery review. It was felt that providing an on-site thoracic surgeon at the opening of the MTC offered an important opportunity for training and development of trauma and orthopaedic teams. Clear cover arrangements are very important.

    - **Expert advice on the level of activity required to maintain a consultant surgeons skills:** thoracic surgeons needs to undertake at least 50 primary lung resections per year and in their view 8 surgeons would mean this target may be difficult to meet. In addition operating time for individual surgeons would be too low. It was suggested it might be a problem to recruit into such a posts.

- **Development of indicative job plans for consultant thoracic surgeons:** There was agreement by all thoracic surgeons present that on current activity 6 surgeons represented the right number however there should be a further assessment if activity changes, for example due to lung cancer screening.

- **Additional advice from the President of the SCTS:** Because he was unable to join the meeting he provided the following email guidance:

  There is no need to ensure that thoracic surgeons are on-site at UHW for trauma as part of job-planning as they will be needed so infrequently.

- **Representative of the All Wales Cancer Network Site Specific Group for Lung Cancer**
  The representative of the All Wales cancer Network Site Specific Group for Lung Cancer commented that the number of surgeons is only one element which needs to be considered and that the way sessions are structured and bed configurations will also need to be factored into planning.

  He was supportive of the proposal to train orthopaedic surgeons in rib fixation.

  He thought the introduction of the Single Cancer Pathway would not have a significant impact on likely demand and any increase would be minimal. However, if Lung Cancer Screening were introduced in Wales, the impact would be significant and would increase not only demand for thoracic surgery but also for other treatments such as Stereotactic Body Radiotherapy. It was noted that this development is probably at least three years away.

  Whilst it has been difficult to quantify due to lack of data, a significant proportion of the current unmet need relates to patients with benign lung disease.

3.4. Conclusion:

It is clear therefore that there is currently differential advice. This appears to be because the original work of the provider Medical Directors takes a longer term strategic view of service needs and also tries to balance concerns which have been expressed to them about the need to ensure sufficient support for the MTC. Taking this into account we have concluded that the following approach allows us to bridge the gap between these different positions:

- Appointment of a 4th locum thoracic surgeon at the UHW to support implementation of the new MTC. This is clearly important in establishing

the new MTC and allows us to test and build confidence in the system whilst the final service model is being determined and was fully supported from the consultation process. The feedback suggests that this should be for 12 rather than 6 months. This appointment would need to be subject to a 6 month review. Also during this time the two thoracic centres would develop plans to work together. The cost of the locum appointment is estimated to be £135,000 based on £125,000 salary (including associated on costs and shared secretarial support.

- The modelling, benchmarking activity and external advice support the view that approximately 6 surgeons are needed to support the single thoracic surgical centre at Morriston Hospital, Swansea based on a 20% increase in activity. However as highlighted above there are differing views which appear to be because of uncertainties around longer term strategic issues. These strategic issues include:

  - MTC workload being higher than that estimated by external experts
  - Further professional advice from the SCTS regarding management of thoracic surgical emergencies
  - Introduction of the single cancer pathway
  - Introduction of lung cancer screening
  - Ability to recruit
  - The development of academic appointments

- An updated review is therefore essential during the 12 months prior to the opening of the single thoracic surgery centre. This will include real world experience from the MTC, updated activity figures, a clearer understanding of the strategic issues highlighted above and the formal professional advice of the SCTC on emergency cover of the major trauma centre. It must also include the previous work undertaken by the two provider medical directors. This will allow a fully informed robust recommendation to be brought back to the Joint Committee well in advance of the move to a single site.

4.0 RECOMMENDATIONS

Members are asked to:

- **Note** the detailed workforce planning and consultation responses.
- **Note** the advice of external experts.
- **Note** the comments from the provider medical directors.
- **Note** the comments of the representative of the All Wales Cancer Network Site Specific Group for Lung Cancer.
- **Support** the recommendations that a locum 4th thoracic surgeon be appointed at UHW to support implementation of the new MTC for 12 months and that this appointment would be subject to a 6 month review.

- **Support** the recommendation that on current activity data and external expert advice regarding the out of hours cover for the MTC that 6 surgeons are required for the new single site service. But that this workforce review is should be reassessed during the 12 months prior to the opening of the new single centre.
- **Support** the recommendations go forward to the six affected health boards and that they be asked to confirm their unconditional approval for a single adult thoracic surgery centre based in Morriston Hospital, Swansea.

5.0 APPENDICES / ANNEXES

Appendix A	Consultant workforce arrangements suggested by the medical directors of SBUHB and CVUHB
Appendix B	Arrangements for addressing the additional assurances requested by Health Boards
Appendix C	Thoracic Surgery Post Public Consultation Lessons Learnt Report
Appendix D	Commissioning Plan for Adult Thoracic Surgery
Appendix E	Detailed workforce planning document
Appendix F	Comments received on draft workforce planning document and WHSSC responses
Appendix G	Notes from the discussion with external expert panel

Link to Healthcare Objectives	
Strategic Objective(s)	Choose an item. Choose an item. Choose an item.
Link to Integrated Commissioning Plan	
Health and Care Standards	Choose an item. Choose an item. Choose an item.
Principles of Prudent Healthcare	Choose an item. Choose an item. Choose an item.
Institute for HealthCare Improvement Triple Aim	Choose an item. Choose an item. Choose an item.
Organisational Implications	
Quality, Safety & Patient Experience	
Resources Implications	
Risk and Assurance	
Evidence Base	
Equality and Diversity	
Population Health	
Legal Implications	

Report History:		
Presented at:	**Date**	**Brief Summary of Outcome**
Choose an item.		
Choose an item.		

DRAFT: Major Trauma Centre: Management of emergency patients with thoracic injuries

Consultant workforce requirements

Situation

This paper sets out the combined view of the Cardiff and Vale and Swansea Bay University Health Board Medical Directors for the Consultant workforce requirements required to implement a sustainable Consultant workforce plan to support the management of emergency patients with acute thoracic injuries as part of the Major Trauma Network for South and West Wales and South Powys. Currently, thoracic surgical services are based at the University Hospital of Wales in Cardiff and at Morriston Hospital in Swansea.

Background

In March 2018, all six Health Boards approved the establishment of the trauma network, in line with the recommendations of earlier independent panel review and following a period of public consultation. This included:

- A major trauma network for South and West Wales and South Powys
- The adults' and childrens' major trauma centres should be on the same site.
- The major trauma centre should be at University Hospital of Wales, Cardiff.
- Morriston Hospital should become a large trauma unit and should have a lead role for the major trauma network.

In November 2018, the five south Wales Health Boards and Powys Health Board, considered the outcome of the public consultation and recommendations on the future of thoracic surgery in south Wales. All Health Boards confirmed, with some caveats and requests for further assurance, their approval of the recommendation for a single thoracic surgery centre at Morriston Hospital, Swansea.

The establishment of the Major Trauma Centre in Cardiff, and a tertiary Thoracic service in Swansea will require the availability of a consultant thoracic surgeon to be available to provide advice and to attend either centre in an emergency 24 hours a day, 365 days of the year. This represents a significant increase in the commitment to out-of-hours work from the current model.

Analysis

The current consultant workforce in thoracic surgery in Cardiff and Vale UHB (CAV) and Swansea Bay UHB (SB) are:

Cardiff and Vale	3 consultants
Swansea Bay	3 consultants (2 in post; 1 vacant post)

For the purposes of this paper it is assumed that, other than the additional volume of out-of-hours work, that the demand for thoracic surgical services remains at the current level. However, it should be noted that during the current planning discussions regarding the establishment of the tertiary thoracic service it has been highlighted that there is likely to be an additional volume of work (e.g. rib fixation) that is not part of current demand. From data presented at the recent first Thoracic Clinical Summit (15.3.2019) in Bridgend it is likely there will be 1200 cases per year and expected growth of 20% in the number of surgical cases.

The external review of the service, provided by the Royal College of Surgeons, considered that 5 surgeons would be sufficient to cover such a rota. However, this does not take into account:

- There is no existing on-call rota and therefore all out-of-hours workload will be in addition to current workload.
- There is a requirement to provide timely input across two geographically separate sites in order to provide safe and effective cover to the MTC as well as improve the outcomes in Thoracic Surgery.
- Taking annual leave and study leave into account, the prospective cover for 5 consultants equates to a 1 in 4 rota, which is not sufficiently robust to deal with sickness or unexpected absence.

The additional workload associated with out-of-hours cover is detailed below and takes into account:

- The Direct Clinical Care (DCC) sessions required to have a consultant thoracic surgeon present on the UHW site between 9am and 5pm Monday to Friday – as has been agreed.
- The additional workload of the on-call rota for out of hours (covering weekday evenings 5pm – overnight, and 24 hours at weekends), with a conservative estimate that this will involve approximately 2 hours/week of additional work.
- Estimated daily hours includes time taken for providing telephone advice, for review of postoperative patients, as well as the more significant annual workload of emergency management of MTC patients. This estimate includes the approximate 5-8 cases that following immediate resuscitative care require the emergency on-site attendance of a thoracic surgeon.

Table 1. Additional DCC sessions required

Daytime

UHW presence	Sessions/week	Sessions/year	Sessions/week per 42 weeks
Monday-Friday	10	506	12.0

Out of hours

7days/week; 365 days/year	Sessions/week	Sessions/year	Sessions/week per 42 weeks
Estimated 2h/day	3.7	194.1	4.62

Total DCC	**16.67**

An intensity banding supplement would also apply in recognition of the frequency of the rota.

This additional volume of DCC activity could only be accommodated through the appointment of 2 additional posts, with the addition of Supporting Professional Activity sessions for post-holders' professional development, as required by the Welsh Consultants' Contract:

Post 1	8 DCC; 2 SPA = 10 sessions
Post 2	8 DCC; 2 SPA = 10 sessions

It is not proposed that these new posts' clinical commitments are isolated to the additional activities identified above, but rather that the sessions are distributed as part of a wider group job plan amongst the new posts and all existing post-holder, to ensure equal distribution of workload supporting the MTC as well as tertiary activity. It is anticipated this would be accommodated with a 1 in 8 "hot" on-call covering the Thoracic Centre in Morriston Hospital and a separate quieter 1 in 8 on-call covering the Cardiff and Vale MTC at the University Hospital of Wales. This would mean an on call overall of 1 in 4 and means there would not be a situation where either centre is not physically covered by a Consultant Thoracic Surgeon.

The sessional requirements and job plans of the whole Consultant body would be subject to a review after 6 months operational working of the new Thoracic Surgical service.

Again data and discussion at the first Thoracic Clinical Summit indicated that each surgeon would require approximately 150 operations a year to maintain their clinical skills. With 8 surgeons, even before the expected increase in number of operations this is achieved with 1200 operations annually.

Recommendation

It is recommended that the appointment of two additional thoracic surgery consultants is required to ensure that appropriate expertise is available 24 hours/day 365 days/year to provide safe and sustainable support for the MTC in Cardiff and the tertiary thoracic service in Swansea.

Dr Graham Shortland
Executive Medical Director, Cardiff and Vale UHB

Dr Richard Evans
Executive Medical Director, Swansea Bay UHB

April 2019

Appendix B: Arrangements for addressing the additional assurances requested by Health Boards

Health Board	Further Assurance Required	Ownership	How the issues are being addressed and actions taken
Hywel Dda UHB	To clarify arrangements for families of thoracic patients as to whether they would have access to family accommodation on the Morriston site.	Thoracic Surgery Implementation Project Board	Update from SBUHB: The existing accommodation for relatives provided at the bottom of the Morriston site will be available for families of thoracic patients, the level of demand required for the expanded thoracic service will be considered according to the agreed service model and if necessary additional accommodation will be included in the business case which will be developed by ABMU for the provision of the new Thoracic Unit.
Hywel Dda UHB	To give further consideration to the issues of transport as raised by people in the Hywel Dda area.	Thoracic Surgery Implementation Project Board	Further work will be undertaken with NEPT when the commissioning framework has been agreed. The commissioning framework will include an assessment of patient numbers and will form the basis on which the NEPT service can be planned. The commissioning framework will be completed by May of 2019.
Hywel Dda UHB	As it was noted that the response provided by WHSSC did not address concerns about parking, WHSSC to provide a response to the issue of	Thoracic Surgery Implementation Project Board	Update from SBUHB: The Health Board confirms that over recent months the parking issues at Morriston had greatly improved due to the demolition of empty accommodation and outdated

	parking raised by people in the Hywel Dda area.		buildings on the site. In addition work is underway to improve access to the Morriston site which will enable planning permission to be sought to further improve car parking on the site.
Hywel Dda UHB	It was noted that there was a lack of clarity on whether appropriate services in Hywel Dda were ready and established to provide onward care after local people had been discharged back to their own Health Board and as such a response is required as to how local services receiving patients discharged from Morriston will provide adequate care.	Thoracic Surgery Implementation Project Board	The implementation project board, led by SBUHB, is establishing a service model working group to develop the detail of how the service will be organised to deliver the service specification. This will include the pathway for discharge back to local services following admission for thoracic surgery.
Hywel Dda UHB	In addition, concerns were expressed around the pathway, with this process offering the opportunity to consider pathways and improve the patient journey. Reference was made to a risk of an over-focus on certain services, such as those relating to cancer, when there are others which are significant, such as benign respiratory disease.	Thoracic Surgery Implementation Project Board	The implementation project board, led by SBUHB, is establishing a working group specifically for benign conditions.
Swansea Bay UHB	The CHC has asked that ABMU Health Board provide more detail to assure the public in the ABM area that any further costs identified during implementation	WHSSC to SBUHB	Under the governance process for implementation of the single thoracic surgery centre, the business case will be developed through the implementation board, on which all involved Health Boards

	would be met by all involved health boards and not solely by ABMU.		are represented, agreed by SBUHB Board and finally approved by the Joint Committee. The costs will be agreed as part of this scrutiny and approval process. The revenue costs of service delivery will be funded by the 6 Health Boards that refer into the service according to the risk share mechanism for specialised services. Any additional costs that will be incurred during the transition period (as the previous services are decommissioned and the new service commissioned) will be identified through the implementation project and funding agreed through the Joint Committee and allocated according to the risk share.
Swansea Bay UHB	The CHC has asked the Health Board to clarify whether families of thoracic patients would have access to existing family accommodation on the Morriston site and to give further consideration to the issues of transport and accommodation raised by people in the ABM area;	SBUHB to provide to WHSSC	The existing accommodation for relatives provided at the bottom of the Morriston site will be available for families of thoracic patients, the level of demand required for the expanded thoracic service will be considered according to the agreed service model and if necessary additional accommodation will be included in the business case which will be developed by SBUHB for the provision of the new Thoracic Unit.

			SBUHB already offers flexible visiting hours which enables families and visitors to attend anytime from 11am to 8pm, 7 days a week, which can improve access for them to see relatives/loved ones. Assistance with travelling costs for those patients who use their own or a family member's transport will be able to reclaim mileage if they are on any of the recognised benefits under the "help with health costs" scheme (including income support, universal credit, pension credit guarantee or if you live permanently in a care home where the Local Authority helps with your costs).
Swansea Bay UHB	The CHC have asked that the Health Board provide a response to the issue of parking raised by people in the ABM area	SBUHB to provide to WHSSC	The Health Board confirms that over recent months the parking issues at Morriston had greatly improved due to the demolition of empty accommodation and outdated buildings on the site. In addition work is underway to improve access to the Morriston site which will enable planning permission to be sought to further improve car parking on the site.
Swansea Bay UHB	Co-dependencies of services: the CHC have asked the Health Board to give further consideration to the issues raised and provide assurance that any impact and necessary mitigation has been considered.	SBUHB to provide to WHSSC	The requirement for additional theatres, critical care capacity, pathology, radiology and other clinical services which will need additional capacity to underpin the new thoracic centre, and the costs associated with these, will be incorporated into the

			business case being developed by SBUHB and the costs therefore incorporated into the WHSSC IMTP so that the costs are shared across the involved Health Boards and not borne only by SBUHB.
Swansea Bay UHB	Staffing: The CHC considered that the response from WHSSC did not fully address concerns about the need for a strong multi-disciplinary team or respond to concerns that staff may not transfer from Cardiff. Therefore the CHC have asked that the Health Board give this further consideration.	SBUHB to provide to WHSSC	Careful staff consultation processes will be developed and undertaken jointly by SBUHB and CVUHB to ensure any issues with continuity and sustainability of staffing for the single unit are identified early and actions taken to mitigate appropriately. We will ensure that appropriate staffing options for minimising risks of loss of staffing are included in the business case as appropriate.
Cwm Taf Morgannwg UHB	The Health Board requested that that they receive a progress report from WHSCC in 6 months' time.	WHSSC to provide progress report	The report to Joint Committee in May 2019 will be forwarded to Health Boards for their May Board meetings.
Cardiff & Vale UHB	After careful consideration of all of the issues and listening to the representations made from both the Senior Clinical Consultant body and the Community Health Council the Board approved all of the recommendations with the caveat to ensure patient safety, the board would regularly be reviewing the detailed workforce model and medical rotas to provide 24/7 thoracic surgery cover for the Major Trauma	WHSSC to CVUHB	The current position with regard to the issue of thoracic surgical cover for the MTC is included in the Joint Committee report May 2019.

	Centre and if it was not assured within six months the Board would withdraw its approval.		
ABUHB	ABUHB confirmed no additional assurances were required by the Board.		
Powys THB	The Thoracic Surgery developments should not negatively impact on other services for Powys residents from Morriston Hospital; reassurances that outreach/outpatient services would be maintained at Nevill Hall and Glangwili [if the main adverse impact is around travel, and the main mitigation is to keep as much of the pathway as close to home as possible, then we need a level of reassurance that neighbouring service reconfigurations won't lead to these services moving from the nearest hospitals for our residents]	Thoracic Surgery Implementation Board	The implementation project, led by SBUHB, has held a clinical summit where the model was discussed, and is establishing a service model working group to develop the detail. This work will design a model to meet the service specification which requires that out-reach clinics form a key part of the service.

GIG CYMRU NHS WALES

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)

Welsh Health Specialised Services Committee (WHSSC)

Thoracic Surgery Public Engagement & Consultation

A Review of the conduct of the project and key lessons learnt

Paul Williams (Cwm Taf LHB - Welsh Health Specialised Services Committee)

Abstract: This document provides an overview of the delivery of a formal public consultation on the location of adult thoracic surgery services for the population of South Wales together with a description of the lessons learnt during the conduct of the project.

Project Title:	Thoracic Surgery Public Consultation
Program Title:	Provision of Adult Thoracic Surgery in South Wales
Author:	Assistant Planning Manager WHSSC
Report Title	Review of the conduct of the project and key lessons learnt
Brief description of context	WHSSC is a Joint Committee of the seven Local Health Boards (LHBs) in Wales. The seven LHBs are responsible for meeting the health needs of their resident population, and have delegated the responsibility for commissioning a range of specialised services to WHSSC. Specialised services generally have a high unit cost as a result of the nature of the treatments involved. They are a complex and costly element of patient care and are usually provided by the NHS. The particular features of specialised services, such as the relatively small number of centres and the unpredictable nature of activity, require robust planning and assurance arrangements to be in place to make the best use of scarce resources and to reduce risk. Specialised services have to treat a certain number of patients per year in order to remain sustainable, viable and safe. This also ensures that care is both clinically and cost effective. Thoracic surgery is one of the specialised services that WHSSC commissions for the people of Wales. For patients living in North Wales this service is provided by Liverpool Heart and Chest Hospital NHS Foundation Trust. This is one of the largest thoracic surgical centres in the United Kingdom, with six consultant surgeons, serving a catchment area that spans across the north west of England and North Wales. Patients in northern Powys access the thoracic surgery service at Heartlands Hospital, Birmingham, which has recently become part of the University Hospitals Birmingham NHS Foundation Trust. By contrast, in South Wales there are two smaller services based at Morriston Hospital, Swansea and the University Hospital of Wales, Cardiff. The service at Morriston has two consultant surgeons, whereas the service at the University Hospital of Wales, has three consultant surgeons. There has been concern for a number of years that these two smaller services are not sustainable, and may not be able to fully meet the needs of the population of South Wales. The Thoracic Surgery Review Project comprised two distinct stages. Stage One aim was to determine the service model for South Wales, i.e. one thoracic surgery centre or two and depending on the outcome of Stage One, Stage Two's aim was be to determine the location of the service centre.

	A Project Board was established to form recommendations on the future provision of adult thoracic surgery in South Wales. The Project Board was informed by a review of the adult thoracic surgery services which was undertaken by the Royal College of Surgeons. Following an extensive engagement exercise across South Wales, in which the views of service users and other stakeholders were sought on the information required in order to make a recommendation on the future provision of thoracic surgery services in South Wales, the Project Board recommended that a single thoracic surgery centre should be developed for South Wales. WHSSC sought advice from the Board of Community Health Councils and Legal Services on the requirement to engage or consult on each of these two stages. The advice provided for stage one was that whilst it is not necessary to carry out formal consultation, engagement was necessary. Following the recommendation from the Project Board, an Independent Panel was convened to review the options for locating the centre and to make a recommendation on the preferred location for the single thoracic surgery centre. The Independent Panel recommended that Morriston Hospital should be the location for the proposed single thoracic surgery centre. The recommendation from the Project Board and the recommendation from the Independent Panel were considered and endorsed by the WHSSC Joint Committee for further consideration by the six affected health boards, subject to further discussions with the Community Health Councils about the need for public consultation. Following the discussions with the Community Health Councils, it was agreed that the affected health boards, with assistance from WHSSC, should be asked to consider undertaking a formal public consultation in which they would ask the public, staff and interested organisations for their views on the recommendations of the Independent Panel to locate the single thoracic surgery centre at Morriston Hospital.
Brief description of project	WHSSC in order to support the decision making process for the review of Thoracic Surgery services in South Wales entered into a period of public engagement utilising public meetings and digital channels throughout the South Wales region. Responses were requested for four questions 1. Is there any other information you think we should consider to decide whether we need one or two thoracic surgery centres in South Wales? 2. Is there any other information you think we should include in the criteria that will be used by the independent panel? 3. Do you have comments on the process we are using to inform recommendations on future thoracic surgery services? 4. Do you have any other comments on the information presented in this document?

	In total we received 78 responses including feedback captured during the public meetings the most common themes were • Travel impact • Co-location with other services and infrastructure • Capacity in general with current services and ability to deliver a future high class service. • Comments on the process and or documentation adopted. The recommendation from the Project Board and the recommendation from the Independent Panel were considered and endorsed by the WHSSC Joint Committee for further consideration by the six affected health boards, subject to further discussions with the Community Health Councils about the need for public consultation. Following the discussions with the Community Health Councils, it was agreed that the affected health boards, with assistance from WHSSC, should be asked to consider undertaking a formal public consultation in which they would ask the public, staff and interested organisations for their views on the recommendations of the Independent Panel to locate the single thoracic surgery centre at Morriston Hospital. To ensure the consultation process was meaningful, consideration was given to key messages to be shared with the public and the evidence available to support the proposed development of a single adult thoracic surgery centre at Morriston Hospital, serving patients from South Wales. The key messages included: • Over the last year, patients in Wales with lung cancer have waited longer than they should have for surgery • Patients in Wales with lung cancer have some of the lowest survival rates in Europe, although we know we have expert surgeons • Patients who need surgery, but do not have lung cancer, have very long waiting times, and our doctors and nurses tell us this is affecting the quality of care they can provide • Thoracic surgery is becoming increasingly specialised and better outcomes come from larger centres (elsewhere in the UK and Europe, services are being reorganised into larger centres) and • Changes in the way surgeons practise mean we cannot continue to staff our two units in the way we have done in the past • The Royal College of Surgeons undertook a review of the services in south Wales and recommended that in order to provide sustainable and high-quality thoracic surgery, there should only be one hospital delivering the adult service – "It is the review team's recommendation that WHSSC adopts a single site thoracic surgery service model for South Wales. The review team considered that this reconfiguration was in the best interests of patient care and was the most

	sustainable option for thoracic surgery going forward. It was considered that changes to cardiac and adult thoracic surgery would mean there would not be a staffing resource that could adequately sustain a two site model in the future..." • An Independent Panel, made up of a range of clinical experts from north Wales and England, patients or their relatives, an equalities representative, representatives from the third sector (voluntary and charity organisations) and an independent Chairperson, were asked to look at the options and make recommendations on the location for the single centre using the criteria developed during the engagement process and agreed by the Project Board. The Independent Panel recommended that Morriston Hospital should be the location for the proposed single adult thoracic surgery centre. • The surgical element of care forms only one part of the overall service patients will receive, and patients will continue to see their local respiratory consultant and have their diagnostic tests at the same hospital where they would currently. • Patients resident in the areas served by Abertawe Bro Morgannwg University Health Board (ABMUHB), Hywel Dda University Health Board (HDUHB) or those areas of Powys Teaching Health Board where patients receive their secondary care at either ABMUHB or HDUHB, would continue to have their thoracic surgery at Morriston Hospital, Swansea. • Patients who would have had their thoracic surgery in UHW, Cardiff, would in future receive their surgical care at Morriston Hospital, Swansea. This includes patients who live in the areas covered by Aneurin Bevan University Health Board, Cardiff & Vale University Health Board, Cwm Taf University Health Board and parts of Powys Teaching Health Board where patients receive their secondary care at one of these health boards. • Evidence shows that thoracic surgery patients are likely to have better outcomes (survive longer, with fewer complications from their disease or treatment) and quicker recovery when treated in larger thoracic surgery centres; • A larger single adult thoracic surgery centre will be more resilient, i.e. more able to cope with unpredictable changes such as episodes of staff sickness, vacancies and changes to national government policy. The consultation asked people to respond to two questions: 1 The Independent Panel recommended that the adult thoracic surgery centre serving patients from South and West Wales and South Powys should be located in Morriston Hospital Swansea. Do you agree or disagree with the proposal? 2 If we develop the adult thoracic surgery centre for South East and West Wales and South Powys in Morriston Hospital in Swansea, what are the important things that you would like us to consider about the planning and delivery of the new service?

	The consultation plan outlined the methods and proposed process for the consultation that will support delivery of the following objectives: • To seek the views of stakeholders on the proposed model for delivering adult thoracic surgery services in South Wales. • To describe and explain the proposed model for delivering adult thoracic surgery services in South Wales. • Ensure awareness and information about the consultation reaches the majority of health board stakeholders and provides opportunities for feedback. • Provide stakeholders with a range of opportunities, taking account of accessibility, for staff and other key stakeholders to give their views by the close of the consultation exercise • To ensure that the consultation process complies with legal requirements, Welsh Government guidance and duties. Advice on the documentation was sought from the Health Boards and Community Health Councils within the regions, in order to ensure that it was fit for purpose. WHSSC was responsible for printing and distributing hard copies of the consultation document, which was available in Welsh and Easy Read formats. The consultation document detailed: • The background to the consultation • The need for change • The proposals for change and rationale for the proposed model • How people can participate in the consultation and give their views The full consultation document in English and Welsh was available in standard and easy read versions also in electronic format. Versions were available in Audio (in English and Welsh) and British Sign Language format on the website. All versions of the document included details of how people could respond online, by email, by phone or by freepost. Other formats would be produced as appropriate on request.

	A full range of supporting and technical documents were available online, providing background information to support and inform the public consultation. These included: • Equality Impact Assessment; • Pre-consultation documents and reports; • Relevant documentation from national bodies (e.g. Royal College of Surgeons); • Other information to inform the decision making process and demonstrate that the options have been thought through and can be implemented; • An initial list of frequently asked questions which were updated as queries arise during the consultation In addition to these documents, a standard presentation was compiled and made available for health boards to use at public and stakeholder events. Alongside the main consultation document the following methods for sharing information were employed: • Website A web page for the consultation was created via WHSSC at the following address: http://www.whssc.wales.nhs.uk/thoracic-surgery-services-in-south-wales There was both an English and Welsh web page and a short film produced outlining the key elements of the consultation. • Public Sessions Across the consultation period there are a number of planned sessions led by health boards in each region. This provided the opportunity for staff, stakeholders and the wider public to provide feedback on the proposals in the consultation document. Members of the WHSSC Executive team supported these sessions. • Mid-Point Review A formal review meeting was held approximately half way into the consultation to consider responses to the consultation, address any issues of concern and consider the need to make adjustments to the approach for the remainder of the consultation period. This was coordinated by WHSSC, and included the engagement leads from each of the health boards, as well as representatives from the Community Health Councils. A report was produced following the meeting, summarising the key themes from the responses received to date, and was shared with the health boards and Community Health Councils. The report identified a number of actions including additional work around a key issue that had emerged during the first half of the consultation around the arrangements for delivering Thoracic Surgery

	support to the Major Trauma Centre. This work was subsequently included in the evidence pack provided to HBs with the consultation outcome. • Post Consultation Phase 804 responses were received with the majority being submitted via the online form. Each individual response was recorded on a log which was regularly shared with affected health boards and CHC's Where notes from staff or public events were provided these were also captured and included within the analysis and consideration of implementation actions but were not been recorded as individual responses. On behalf of the six affected health boards, WHSSC received and logged responses to the consultation, the outcomes of which was reported to the WHSSC Joint Committee in September, prior to submission to each of the health boards, together with a recommendation on the proposal, for consideration at public board meetings to be held before the end of October 2018. WHSSC worked with the health board engagement leads, and provided them with the responses specific to their health board area and region. WHSSC officers reviewed, collated and analysed the responses and outcomes with regards to any national, regional or crosscutting themes, in order to enable the Joint Committee and affected health boards to have an informed discussion on the outcome of the consultation. WHSSC officers shared all of the responses with the Community Health Councils and health board engagement leads, and reviewed and collated the responses and outcome for each health board area. This information was also shared with the Community Health Councils for consideration as part of their role in reviewing and formulating an official response to the consultation.
	Final Project Review A formal review meeting was held in the spring of 2019 to consider conduct of the consultation and address any issues of concern. This was coordinated by WHSSC, and included the engagement leads from each of the health boards, as well as representatives from the Community Health Councils. This report was produced following the review meeting, and summarises the key findings under four headings • Key project successes

	• Project shortcomings and solutions • Lessons learnt • Follow-up Actions
Key project successes	**Please describe what has worked well.** **What have been the key successes of this project?** • The primary success of the process was to deliver a regional engagement and consultation. • There was a due regard to equity of opportunity, the approach adopted resulted in a wide range of stakeholders sharing their views. This was supported by the availability of materials in multiple formats. • As themes and questions developed throughout the consultation period WHSSC worked collaboratively with CHC's and HB's to produce a living Frequently Asked Questions process to signpost or address issues raised. • High Response Rate with 804 individual responses across all affected populations. Strong engagement with clinicians. • Feedback from CHC's and HB's was that WHSSC demonstrated a genuine desire to engage and consult, as evidenced by WHSSC Executive support at public and staff meetings. **What factors supported this success?** The adoption of a two stage process with engagement followed by consultation allowed WHSSC to refine and adapt internal processes and in particular shape its communication strategy. There was an opportunity to learn from the public consultation on Major Trauma and in particular the approach to collaborative working. Regular contact with Health Board and CHC's was a core component of the process and space was created to have conversations throughout the consultation period. The Mid-Point Review was very useful in framing the quantitative and qualitative approach taken and offering an opportunity to discuss and tailor the process, including providing the opportunity to undertake additional work on a specific issue in response to feedback received during the first half of the consultation. As noted above there was a genuine desire to engage and consult and WHSSC executive team took an active leadership role throughout the process.

	There was a recognition that subject matter experts existed within the HB's and CHC's, collaborative working and transparency were taken as key lessons from the major trauma consultation and informed the WHSSC process throughout.
Project shortcomings and solutions	**Please describe what have been the main challenges of this activity?** Above all else the fact that conducting a two stage engagement and consultation process was a new endeavour for WHSSC. When planning the process and materials to be adopted consideration was given to build sufficient flexibility in the timeline to ensure all activity was completed in order to account for the agreed recommendation and decision making processes within Joint Committee and the Health Boards. However, it is recognised that the pre consultation stage included a number of challenges which resulted in the timeline being stretched, in effect the contingency was utilised at the start of the process. Examples of early pressures within the timeline included; There was a degree of uncertainty regarding the need for a public consultation. Time was lost when WHSSC were gathering the views of the CHC's. Engagement leads felt that their earlier involvement would have been beneficial, building on their expertise and local relationships. Timescales need to take account of the decision-making timescales for CHCs as well as HBs. Once the need for a consultation was agreed there was a significant amount of activity dedicated to producing and reaching consensus on the material. The decision to include an agree/disagree question was an example of early uncertainty over what was being consulted upon. Post consultation there were challenges over the governance and decision making process and in particular the ability to share materials with CHC's prior to the HB meetings. **How were they overcome (if they were)?** In recognition of the uniqueness of the activity from a WHSSC perspective collaboration with Health Boards and CHC's was adopted throughout the process. The timeline although stretched did have a sufficient contingency to allow the process to be completed in time. The governance around the recommendation and decision making process was complex and reflected the uniqueness of WHSSC's position outside but acting on behalf of the Health Boards. To mitigate WHSSC continued to engage with Health Boards and CHC's throughout the process, for example by providing regular copies of the responses logged. The mid-point review was extremely helpful in enabling joint working to resolve a number of issues.

Were the project objectives attained? If not, what changes need to be made to achieve these results in the future?

Objective 1: To seek the views of stakeholders on the proposed model for delivering adult thoracic surgery services in South Wales.

804 responses have been received, with the majority being submitted via the online form. Each individual response was recorded on a log which was regularly shared with affected health boards and CHC's.

Where notes from staff or public events were provided, these have also been captured and included within the analysis and consideration of implementation actions, but they have not been recorded as individual responses.

In response to the question

The Independent Panel recommended that the adult thoracic surgery centre serving patients from South and West Wales and southern Powys should be located in Morriston Hospital, Swansea. Do you agree or disagree with the proposal?

- 339 or 42.16% agreed with the proposal.
- 428 or 53.23% disagreed with the proposal.
- 34 or 4.23% neither agreed nor disagree with the proposal.
- 3 or 0.37% did not answer the question.

A number of themes were identified when analysing the responses. These "key" themes have been used as the basis of analysis of the responses.

Many of the 804 respondents expressed multiple views across their responses and therefore the total number of issues identified within the themes is 1,441.

The key themes were as follows:

- Implementation and Improvement
- Accessibility
- Major Trauma Centre
- Workforce
- Other

Objective 2: To describe and explain the proposed model for delivering adult thoracic surgery services in South Wales.

Advice on the documentation was sought from the health boards and Community Health Councils within the regions, in order to ensure that it was fit for purpose.

	WHSSC was responsible for printing and distributing hard copies of the consultation document, which will be available in Welsh and Easy Read formats. The consultation document detailed: • The background to the consultation • The need for change • The proposals for change and rationale for the proposed model • How people can participate in the consultation and give their views The full consultation document in English and Welsh was available in standard and easy read versions in both hard copy and electronic format. Versions were also be available in Audio (in English and Welsh) and British Sign Language format on the website. All versions of the document included details of how people could respond online, by email, by phone or by freepost. There were no requests for other formats although the plan included provision for them to be produced as appropriate on request. A full range of supporting and technical documents were available online, providing background information to support and inform the public consultation. These included: • Equality Impact Assessment; • Pre-consultation documents and reports; • Relevant documentation from national bodies (e.g. Royal College of Surgeons); • Other information to inform the decision making process and demonstrate that the options have been thought through and can be implemented; • An initial list of frequently asked questions which was updated as queries arose during the consultation In addition to these documents, a standard presentation will be compiled and made available for health boards to use at public and stakeholder events. A review was held at the half way point of the consultation with representation from the affected health boards and CHCs to consider the processes and responses to date in light of the consultation plan and national guidance. Actions arising from the mid-way review were: • A mechanism was agreed for reporting by health boards of any exceptions to the published consultation plan; • An agreement was reached for the provision of the verbatim responses, together with high level quantitative analysis, to health boards and CHCs on a weekly basis; • The addition of a new FAQ relating to the requirements of the Major Trauma Centre for emergency support from consultant thoracic surgeons; • The addition of a new FAQ relating to the lay membership of the Independent Panel; • Steps were taken to ensure that work was undertaken to provide outline arrangements for delivering thoracic surgery support to the Major Trauma Centre (for the small number of cases where this may be required). This

information was included in the evidence pack that will be submitted to health boards with the consultation outcome.

Objective 3: Ensure awareness and information about the consultation reaches the majority of health board stakeholders and provides opportunities for feedback.

In order to assess the public reach of the consultation, respondents were asked if they were an employee of the NHS. Respondents were also asked if they were replying on behalf of an organisation. Where respondents indicated that they were replying on behalf of a health board this has been discounted from the organisation's total number in recognition that any staff responding were doing so as an individual/group and not corporately.

Not specified	NHS Employee	Organisation	Elected Representative	Grand Total
416	369	16	3	804
51.74%	45.90%	1.99%	0.37%	100%

In line with the statutory duty placed on each health board under the Wales Public Sector Equality Duty 2011, an equality impact assessment (EIA) was undertaken on the proposals for a single adult thoracic surgery centre for South Wales

At the consultation mid-way review, held in July 2018, the opportunity was taken to review the characteristics of respondents to assess whether the consultation was reaching the relevant groups. No issues were identified at the mid-way review which required changes to the consultation plan process. The distribution of responses across the protected characteristics did not change significantly from this point.
The equality monitoring process indicates that overall the consultation did have broadly representative input from affected protected categories and from the relevant age distribution.

Objective 4: Provide stakeholders with a range of opportunities, taking account of accessibility, for staff and other key stakeholders to give their views by the close of the consultation exercise.

The table below quantifies the response method used

Health Board of Residence	Email	Hard Copy	Online form	Grand Total
Abertawe Bro Morgannwg UHB	8	13	177	198

Aneurin Bevan UHB	2	8	44	54
Cardiff & Vale UHB	12	32	291	335
Cwm Taf UHB	1	16	25	42
Hywel Dda UHB	1	38	66	105
Powys THB	2	4	6	12
Not indicated	12	9	37	58
Grand Total	**38**	**120**	**646**	**804**

Public events were arranged throughout the consultation period and a schedule was published on the WHSSC website.

Attendees were asked to submit their individual responses and a record of themes identified has been provided. No themes were identified which have not been represented in the analysis of responses from the standard response methods.

A number of staff and stakeholder events were held through the consultation period. Attendees were asked to submit their individual responses and a record of themes identified has been provided. There were no themes identified which have not been represented in the analysis of responses from the usual response methods.

Objective 5: To ensure that the consultation process complies with legal requirements, Welsh Government guidance and duties.

A consultation plan was developed, in collaboration with health board engagement leads, to support the consultation process.

The consultation document, response form and covering letter were prepared by WHSSC and formally approved by the six affected health boards at board meetings in June 2018. The consultation document was also available in the Welsh language, an Easy Read format and as a BSL signed video.

An Equality Impact Assessment ("EIA") was also completed and used to inform the consultation plan and the stakeholders that should be consulted. In order to assess the demographic profiles of respondents, the hard copy and online versions of the consultation document included a series of survey questions in multiple choice format

The consultation was developed to meet the requirements of the framework for Welsh NHS bodies and Community Health Councils established in 'Guidance on Engagement and Consultation on Changes to Health Services' issued by Welsh Government in March 2011 and the principles in 'National Principles for Public Engagement in Wales' developed by Participation Cymru and endorsed by Welsh Government in 2011.

	In addition, the consultation was designed to satisfy the 'Sedley criteria' (often referred to as the 'Gunning principles') originally set out in 1985 and endorsed by the Supreme Court in *R (Moseley) v Haringey London Borough Council in 2014* and subsequent judicial developments in which guidance on the requirements of fair consultation was set out and which has also been taken into account.
Lessons learnt	**What could have been done differently/ better?** This was a new endeavour for WHSSC and it was a steep learning curve for organisational understanding of the complexities of delivering a regional engagement and consultation. The support and advice of the subject matter experts was sought at an early stage as was the views of the CHC's. It is recognised by WHSSC that the advice of engagement experts regarding the need for public consultation should have been accepted at an earlier stage. A greater understanding of the role of the CHC's would have avoided delay at the outset. The process delivered a regional consultation but delivery was undertaken at a local level and although the process included regular checks and updates the activity undertaken locally reflected local circumstances and therefore included inherent inconsistencies. A suggested approach would to be adopt a program management approach with a fully developed handling plan to account for and where possible remove any inconsistencies. Such an approach would ensure greater clarity on roles and responsibilities and facilitate robust governance in relation to reporting, escalation and communication across the programme. Transparency was at the heart of the process up to the decision making stage at Health Boards. There is a recognition of some frustrations within CHC's with the ability to obtain, assess and comment on material before it is public. Although every effort was made to identify an effective communication strategy within the overall consultation plan there were a few examples, where communication between stakeholders could have been improved: • Communication management around the alignment of the publication of recommendations and decisions statements from different health boards could have been better aligned? • Improving the communication between the local CHCs and their Health Boards for example by establishing a formal communication channel via the Directors of Planning at each Health Board • Clarity of communication and explanation of the Gunning principles

	What would you recommend to improve future programming or for other similar projects elsewhere A theme that emerged from the Major Trauma consultation was around the need for improved collaborative working across NHS bodies. This has led to the establishment of a Cross Health Board Consultation working group which includes representation from WHSSC. The conduct of the engagement and consultation has always been mindful of the guidance and relevant legislation and case law but there is a gap in the guidance on collaborative which should be addressed. NHS bodies should engage with the Consultation Institute and consider the commissioning of training for all staff to increase awareness of the law and guidance regarding engagement and consultation. **What mistakes should be avoided if the initiative were to be replicated?** The recommendation and decision making process was reflective of this being a regional process and it is recognised that there were frustrations with CHC's with regard to the availability of the supporting material before it was made public. Consideration should be made to detailing the flow of information and gaining commitments on confidentiality if shared prior to being in the public domain. The overall timeline of the activity was flexed early and without scope for extension due to the agreed decision making process deadlines significant pressure was placed on the analysis of the data. This pressure was exacerbated by a large number of late submissions. Although overcome by allocating additional resource future program management should include a strategy for mitigation for slippage in the timeline.
Follow-up Actions	As part of the Final Review, follow-up actions and areas for exploration were: • WHSSC to contribute to the Cross Health Board Consultation Working Group • Regular meetings to be held between WHSSC and HB Engagement Leads • Regular meetings to be held between WHSSC and the CHC's

	• Improved communication between WHSSC and the HB DoPs • Agreement that to avoid the issue around information in the public domain the process is adopted that it can be shared in confidence to the CHC executive. • WHSSC to engage with all staff to increase awareness of engagement.

Commissioning Plan for Adult Thoracic Surgery

Contents

1. Introduction

This purpose of this document is to set out the commissioning plan for thoracic surgery in south Wales. The commissioning plan contains the following components:

- Service specification and commissioning policies
- Population demand assessment
- Performance management framework
- Contractual framework

In addition, transitional commissioning arrangements will need to be developed to support the decommissioning of the old services and establishment of the new service. These will be developed alongside the transition plan for implementing the new service.

2. Service Specification and Policy Development

2.1 Service Specification

The service specification sets out the requirements and quality standards for the thoracic surgery service. The thoracic surgery service specification was developed as part of the Thoracic Surgery Review and was published in March 2017. A copy of the specification is attached to this document (Appendix A). A formal review of the specification is scheduled for March 2020.

Key Principles of the Specification

The aims of the specification are to provide a sustainable, high quality, equitable service that is patient centred and optimises the quality of patient and family experience (a full description of the objectives is set out in section 2.2 of the specification).

The specification describes a service model based on a thoracic surgery centre with dedicated facilities (theatres, ward, HDU) for the delivery of surgery, with the out-patient components of the service delivered through a network of clinics held both at the thoracic surgery centre and in other locations across the region. Apart from the admission to the thoracic centre for surgery, the other components of the service (first out-patient appointment with the surgeon, post surgical follow-up, pre-admission assessment)

should be delivered, where possible, on an outreach basis closer to patients' homes.

This principle was also supported by the outcome of the public consultation on the proposal for a single thoracic surgery service at Morriston Hospital, which emphasised local provision where possible to maximise accessibility and mitigate the impact of additional travel for patients and families.

The new thoracic surgery service will be expected to meet the requirements and quality standards in the specification. WHSSC will influence compliance with the specification as a member of the Implementation Board and when scrutinising proposals from the Implementation Board for recommendation to the Joint Committee.

2.2 Commissioning Policy Development

Commissioning policies specify criteria for treatment and the referral pathway to a service. At the current time, WHSSC does not have specific commissioning policies for thoracic surgery. Patients are referred for lung cancer surgery through the established pathway via the lung cancer MDTs; referrals for non cancer conditions are received directly from respiratory physicians.

In February 2019, the Thoracic Surgery Review Project Board considered areas for policy development and identified the following two areas:

- Surgical assessment and operative treatment of non-cancer thoracic diseases

It is recognised that there is unmet need for thoracic surgery for non-cancer thoracic conditions. Due to capacity constraints, patients are often treated medically (e.g. for empyema or pneumothoraces) when they might have obtained better outcomes from thoracic surgery. The Royal College of Surgeons report to WHSSC on thoracic surgery in south Wales (January 2017) also highlighted the issue of under provision for these patients.

The development of a commissioning policy will set out the criteria and process for referral to thoracic surgery in order to define which patients would benefit from surgery, ensure consistency in the criteria applied across Wales and improve equity in access to thoracic surgery for these conditions. The development of the

policy will need to be matched to the availability of capacity in the new service to meet the increase in referrals.

- Surgical techniques (in particular, Minimally Invasive Surgery and the role of robotic surgery)

As in other areas of surgery, robotic assisted surgery is a developing technology within thoracic surgery. A modern thoracic surgery service will need to have the capability to use robotic surgery where it provides better patient outcomes and is cost effective. To support the future development of robotic capability, a policy will be developed for surgical techniques to identify where this technology adds most value. This policy development will be informed by the evidence review that is being undertaken by Health Technology Wales.

In addition to these two areas, WHSSC will also take into account policy development taking place in NHS England. NHS England has recently developed a commissioning policy for surgery for pectus deformity and has undertaken stakeholder engagement on the draft proposals. When this policy is published, it will be taken through WHSSC's established process to determine if NHS Wales should adopt the same criteria.

The proposed timeline for policy development is summarised in the table below:

Priority Area	Product	Timeline
Non Cancer Thoracic Surgery	Commissioning Policy	For development in 2019/2020
Surgical techniques	Commissioning Policy	For development in 2020/2021
NHS England policy development	Commissioning Policy	In response to NHSE policy publication

3. Population demand assessment

The activity requirement for a single thoracic surgery centre in South Wales is outlined in appendix B. This information is intended to inform the assessment of the capacity requirement to

accommodate a thoracic surgery service for South Wales within SBUHB.

WHSSC has previously sought advice over published sources of comparative data for rates of thoracic surgery to treat non cancer indications. This has established that this data is not currently available.

A pragmatic approach has been taken to allow for the flexibility to increase capacity by up to 20% across the casemix to meet future increases in demand and unmet need for non-cancer indications in particular. This has been compared with an alternative approach of estimating the increase in total activity if the ratio of cancer to non-cancer was 50:50 (on the basis of clinical advice that this is an appropriate benchmark for the balance between cancer and non-cancer surgery). These two approaches have produced very similar estimates of the increased activity requirement of up to 1300 cases from the current level of approximately 1100.

The single centre should:

- Have capacity to treat the current levels of demand, and casemix, presenting to each centre (appendix B);
- Treat patients within the targets set out in the thoracic surgery performance framework;
- Have the ability to increase capacity to meet the expected increasing trend of lung resections in the short to medium term;
- Have the ability to provide a timely service for patients who require urgent care for non-cancer indications;
- Have the ability to increase capacity to be able to treat previously unmet need;
- Have the flexibility to increase activity by 20% to accommodate future growth in demand for resections and unmet need for non-cancer indications.

4. Contractual Framework

The aim of the contract model will be to incentivise activity in order to meet the commissioning objectives of delivering high resection rates for lung cancer and treating previously unmet need.

The contract model will be based on the following principles:

- The provider will be funded on the basis of activity delivered;
- Each unit of activity will be funded according to a set of full cost casemix prices;
- The risk of over performance will be held by the commissioner: activity above contract baselines will be funded at full cost prices;
- The risk of under performance will be held by the provider: activity below contract baselines will be retained by the commissioner at full cost.

There are two options to implement this approach: i) to adopt the NHS England tariff prices for thoracic surgery, or ii) to develop an alternative set of full cost prices.

The detailed work to develop the contractual framework will be undertaken alongside implementation planning in order to establish a fully costed case mix contract.

5. Performance Framework

The service specification states that the service should:

- provide evidence of quality and performance controls and procedures;
- provide evidence of compliance with standards of care.

The thoracic surgery performance framework, which sets out measures and reporting frequency, is attached as appendix C. The performance framework includes the following components:

- Activity performance against contract baseline
- Reporting of adverse events/SUI
- Process measures (including performance against cancer and elective waiting times targets)
- Clinical outcomes: data submissions to national registries and audits for benchmarked comparison with UK (including the Society for Cardiothoracic Surgery database, National Lung Cancer Audit)
- Patient Report Outcome Measures / Patient Reported Experience Measures
- Efficiency measures (length of stay)

Annual Service and Outcomes Review

In addition to regular performance reporting to WHSSC, annual review of outcomes and performance will be held. This will provide the opportunity for the following:

- Providing assurance to commissioners on clinical outcomes, PROM/PREM;
- Comparing performance of service providers with national benchmarks across a range of process and outcome measures;
- Sharing good practice;
- Identifying opportunities for future service development.

7. Appendices

Appendix A: Thoracic Surgery Service Specification

Appendix B: Thoracic Surgery Demand

Appendix C: Performance framework

Thoracic Surgery Single Site Consultant Workforce Model- Consultation 07.06.19

Context

The Joint Committee of Welsh Health Specialised Services Committee (a committee of all the health board chief executives and 3 independent members) considered in November 2018 the recommendations that thoracic surgery should move to a single site model and that single site should be located at Morriston Hospital, Swansea. The committee supported this recommendation but asked for a number of assurances regarding the future model and specifically asked for a workforce plan, within 6 months, which described how thoracic surgical cover would be provided to the Major Trauma Centre at UHW, Cardiff.

In May 2019 a proposal regarding the workforce model was submitted by the two provider (Swansea Bay and Cardiff and Vale University Health Board) medical directors to the Joint Committee however the committee deferred a decision and requested that Dr Sian Lewis (and the WHSS Team) bring a WHSSC workforce assessment back to the Joint Committee by the end of June 2019. They asked that this assessment take into consideration a number of matters and some uncertainties raised in the paper and during the meeting.

This paper summarises this initial assessment of the optimal consultant work force model. There are a number of assumptions in this modelling work and this paper is therefore being circulated for comments which will be incorporated into the final submission to the Joint Committee. In addition the WHSS team is establishing a panel of expert external advisors who will also provide feedback.

The timescale for this consultation process is extremely challenging; we apologise for this but we are working within the requirements of the Joint Committee. To help with this rapid turn-around it is important that your comments are returned on the attached template and reference the relevant line within the paper. Also it is important that you provide wherever possible independent evidence rather than opinion to substantiate your comments.

Background

The following assessment is based on;

- a number of points made in the RCS Invited Review 2016,
- the WHSSC Service Specification for Thoracic Surgery
- NHS England Service Specification for Thoracic Surgery
- The current activity levels of the two units plus 20% additional workload

The Thoracic Surgery Implementation Group is working to define the service model so this assessment is also based on a number of assumptions. These assumptions come from comparators with other thoracic surgery centres, presentations made by two consultants (MK and PK) at the recent thoracic clinical summits in March and May 2019.

The RCS Invited Review (2016) stated that;

"In line with units of a similar size it was considered that five consultant thoracic surgeons were required to service a population of 2.4 million people safely. This would provide adequate emergency on-call cover as well as other services to ensure adequate patient throughput. RCS Invited Review 2016".

Additionally the "review team concluded that there were too many separate MDT meetings per week and considered that it would be appropriate to merge meetings. This would place fewer burdens on consultant surgeons attending multiple MDT meetings".

The RCS also recommended that;

Five consultant thoracic surgeons should be employed to meet service demands. Each of the consultants' job plans should include:

- one in five on-call duty which includes weekend cover
- At least one specified operating day
- Fair distribution of MDTs with adequate cross-over cover
- Attendance at out-patient clinic

It is acknowledged that at this point the location of the MTC had not been determined.

The independent panel and the final recommendation from Joint Committee including further mitigations required by Health Boards means that there are other fixed points;

- A commitment to 6 consultant on the basis that this would allow 9.00am to 5.00pm onsite cover at the UHW site and an additional 20% workload (based on outturn + 20%).
- A commitment to the development of the skills of the trauma team to manage immediate thoracic trauma.
- That there will be an on-call thoracic surgery rota which also provides cover to the MTC, and will be in the form of remote advice to the trauma team 24/7 plus attending the MTC in the rare event that their specialist surgical intervention skills are required to support the trauma team;
- There will be a thoracic surgery presence on the University Hospital of Wales site 5 days a week for advice and support for major trauma and other clinical services as required.
- That we will obtain and act upon advice from the Wales Cancer Network to improve the way our multi-disciplinary teams work, ensuring that wherever possible care is delivered closer to home.

Further advice provided to WHSSC at the time of the consultation noted that the Intercollegiate Surgical Curriculum Programme has recently been updated (16th November 2017) to include the requirement that surgeons trained in trauma will allow them to practice independently for injuries to the thorax.

The extant Thoracic Surgery Service Specification Version: 1.0 notes the following key points

With regard to minimum volumes (these are based on the NHS England Service specification)

- The thoracic surgery unit should undertake a minimum of 150 primary lung resections per year.
- The thoracic surgery unit should have a minimum of 3 full time general thoracic surgeons.

Regarding emergency cover and on-call arrangements

- Providers are required to have 24/7 emergency cover by general thoracic surgical consultants with or without mixed-practice cardiothoracic surgical colleagues.
- The surgeons on the rota should be able to deal with the full range of thoracic surgical emergencies.
- Cross cover of rotas from consultants with a purely cardiac practice or from consultants from other specialities is unacceptable.
- A sustainable on call rota should not be more frequent that 1 in 4.

Assessment

Demand Analysis

This demand analysis is based on an estimated population of 2.2 million people.

The table below shows the activity outturn for all procedures over the last 3 years

Table 1 Thoracic Surgery Outturn by Centre

	SBUHB	CVUHB	Total
2016/17	421	615	1036
2017/18	474	646	1120
2018/19	422	672	1094

Source: Provider contract monitoring returns to WHSSC

This shows a fairly static position of approximately 1100 cases per year. For planning purposes this would mean approximately 1300 cases based on outturn plus 20%.

Table 2 shows the casemix for the two centres combined as reported to the Society for Cardiothoracic Surgery in 2017/18.

Table 2 Casemix for Morriston/UHW Combined 2017/18

Procedure	Number of Cases
Lung resections – primary malignant	458
Lung Resection – others	101
Mesothelioma Surgery	16
Pleural procedures	170
Chest wall/diaphragmatic	97
Mediastinal	57

Other	10
Endoscopic	62
Total	**971**

Table 3 Number of primary lung resections

Year and Source	SBUHB	CVUHB	Combined
2016/17 SCTS*	159	194	353
2017/18 SCTS*	162	279	441
2018/19 WHSSC	168	273	441**

*excludes exploratory procedures with no resection
** forecast from M11

Surgical resection is currently the only curative option for lung cancer, therefore long term survival rates are closely related the number of resections carried out at a centre. The table below shows the resection rate for patients across south Wales based on the hospital of referral. This shows a significant variance in lung resection rates from 27% to 13%. The best resection rate across the UK is reported from Papworth Hospital at 28%. The aim with a single centre is to consistently increase the resection rate to be amongst the best in the UK and to do this across the region.

Table 4 Lung Cancer Audit 2018 (2017 data)

	Resection rate	Total cases	Number resected
Bronglais General Hospital	15.40%	56	9
Prince Philip Hospital	18.40%	188	35
Withybush General Hospital	15.10%	97	15
Princess of Wales Hospital	27.00%	106	29
Morriston Hospital	22.90%	294	67
University Hospital Llandough	17.10%	290	50
The Royal Glamorgan Hospital	23.10%	152	35
Prince Charles Hospital Site	18.30%	133	24
Nevill Hall Hospital	13.10%	106	14
Royal Gwent Hospital	18.80%	268	50
South Wales	**19.40%**	**1690**	**328**
Wales	**18.30%**	**2179**	**399**

Proposed Activity Requirements

MDTs

At the recent clinical summit meetings the two clinical leads suggested the following MDT configuration based on six surgeons with two surgeons covering each MDT to ensure that there is always a surgical presence at the MDT and to improve consistency of decision making.

Lung Cancer MDT	New Cases/Year (NLCA) 2015)	Surgeon Responsible	Surgeon Cover
SBU HB Morriston MDT (Singleton, Morriston, Neath)	311	Surgeon 1	Surgeon 4
Hywel Dda MDT GGH (GGH, BGH, WGH,PPH)	311	Surgeon 2	Surgeon 5
CTM HB MDT POW	108	Surgeon 3	Surgeon 6
Prince Charles MDT	126	Surgeon 4	Surgeon 1
ABUHB NHH, Gwent	257	Surgeon 5	Surgeon 2
Royal Glamorgan & C&V MDT	407	Surgeon 6	Surgeon 3

With the advent of the new Cwm Taf Morgannwg Univeristy Health Board it could be feasible that PoW, Prince Charles and Royal Glamorgan join as one MDT but for planning purposes the arrangement suggested by the Clinical Summit have been used. It will however be important that any agreed final model reflects the input of the All Wales Cancer Network and the output of their peer review programme.

As suggested also by the two clinical leads, if six surgeons were in post this would provide each surgeon with the following new cases.

Lung cancer MDTs	Total New Cases (NLCA 2015)
Surgeon 1	311 + 126 = 437
Surgeon 2	311 + 257 = 568
Surgeon 3	108 + 407 = 515
Surgeon 4	126 + 311 = 437
Surgeon 5	257 + 311 = 568
Surgeon 6	407 + 108 = 515

Outpatient and Pre-assessment Clinics

The 2018/19 contract monitoring returns for the two centres for outpatient activity is as follows

Cardiff & the Vale University Health Board

New outpatients: 521

Follow Up: 1085

Swansea Bay (inc Bridgend)

New outpatients: 313

Follow Up: 616

Based on the information from other centres in England pre-assessment/outpatient clinics need to run daily and this is usually at the thoracic centre so in this case Morriston. Additionally the two clinical leads further proposed the need for clinics in the peripheral hospitals for cases identified at the MDT. The suggestion is therefore that in addition to the daily clinics in Morriston there are:

- two clinics/week in Cardiff
- one each in the other Health Board areas which could rotate around the hospitals within the Health Board. This would need to be confirmed once the implementation group have finalised their work on the service model.

Pre-habilitation

It is proposed that this occurs at all hospitals but is not consultant led.

Operating Lists

The RCS recommended that each surgeon should have at least one operating list per week. Information from the surgeons at both UHW and Morriston suggest that the most efficient way is to run a long list, essentially equivalent to 3 consultant session days. Advice from both centres also suggests that around 4 cases per long day is an appropriate number.

The planned activity is around 1300 cases/ year, although it is likely to be less than this at the outset based on current figures. So for 4 cases per 3 session list = 325lists/year = 6.25 lists/week.

On call

The RCS report suggested a one in five on-call duty which includes weekend cover for five surgeons so it is proposed that this is a one in six for six surgeons which with prospective cover would equate to around 1 in 5.

Major Trauma Centre

The concerns about cover for the major trauma are acknowledged and it is understood that the "go live" date of April 2020 is a key driver for the urgency required in agreeing the consultant workforce configuration.

Advice provided by the Major Trauma Network Clinical Lead suggests that a thoracic surgeon would need to attend the MTC to deal with an emergency 3 to 8 times per year.

Advice from the two thoracic centres varies one centre stating that they are rarely called in out of hours and the other suggesting that they are called 1 to 2 times per month.

Should there only be one on call rota covering the thoracic surgical centre and the MTC the concern is clearly that the surgeon will be required in both places at the same time. The analysis below is based on the NCEPOD Report from 2003 which carried out a comprehensive review of non-elective surgery. The analysis is based on the figures quoted in that report which are for combined cardiothoracic surgery. We have taken advice from the President of the Society of Cardiothoracic Surgeons regarding the relevance of this analysis to current clinical practice and whilst there have been some changes, including increasing use of rib fixation, it was felt that there was unlikely to be a material difference in the frequency of clinical emergencies. These figures, because they include cardiac emergencies are therefore likely to overestimate of the thoracic surgery emergency workload.

From this analysis, the probability of a thoracic surgery emergency and an MTC emergency arising on the same day is 1 in every 429 days.

The probability of this occurrence in the same hour i.e. at exactly the same time is 1 in every 6,857 days i.e. once every 18.8 years.

Calculation of Thoracic Surgery On Call Probability									
NCEPOD 2003 Non Elective Surgery in the NHS									
Percentage of Non-elective operating									
Cardiothoracic surgery	17.10%								
Operating Time of Day									
	Weekday 08:00 to 17:59	Weekday 18:00 to 23:59	Weekend 08:00 to 17:59	Weekend 18:00 to 23:59	Night 00:00 to 07:59	Total			
Cardiothoracic (n)	120	21	13	2	9	165			
Percentages	72.7%	12.7%	7.9%	1.2%	5.5%	100.0%			
Total Percentage On call window						27.3%			
South Wales Thoracic Surgery total						1,100			
Non elective @17.1% based on cardiothoracic average NEL						188			
Estimated allocation to time of day	137	24	15	2	10	188			
Total in on call window						51			
Probability per day of thoracic case on call						**0.1397**			
Major Trauma Thoracic Surgery Activity						8	per annum		
Weekend						2.3	per annum		
Weekday						5.7	per annum		
Weekday out of hours						3.8	per annum		
Total major trauma estimated for weekend and out of hours						6.1	per annum		
Probability per day of major trauma thoracic case on call						**0.0167**			
Cumulative probability of thoracic case on call and major trauma thoracic case same day						**0.0023**			
Estimated frequency of occurrence same day - 1 in every						429	days	1.2	years
Estimated frequency of occurrence same hour (day * 16 hours) - 1 in every						6,857	days	18.8	years
Assumptions									
1. Thoracic non elective rate equivalent to average across cardiothoracic surgery - in practice cardiac likely to be higher									
2. Assumes all cases performed by surgeon visiting on site and not by advice									
3. Both of these assumptions likely to overstate frequency of occurrence									

On this basis and given the commitment to the development of the skills of the trauma team to manage immediate thoracic trauma the likelihood of the surgeon being required to be in both centres at the same time during the night or on weekends ie when there is no surgeon on site at UHW is extremely low. It is therefore suggested that both the MTC and the thoracic surgical centre can be covered by one on call rota once the surgical centre is established.

Required Consultant Workload Total number of Sessions/week

The following table takes all the analysis above and provides a breakdown across the activities of the number of consultant sessions required per week.

Activity	**Per Week**	**Total sessions Per week**
Theatre sessions	6.25 X 3 session lists	18.75
Pre-assessment and Outpatient clinics	Morriston daily Cardiff 2/week Glangwili/PPH (alternate weeks) Gwent/NHH (alternate weeks)	10

	PoW/PCH/RGH (1 every 3 weeks)	
MDT	6 (not full sessions)	3
On call	Intensity Payment	Intensity Payment
Travel	5 estimate	5
Ward Rounds M-F	5	5
Admin	5	5
Total		**46.75**

Admin and SPAs will need to be added to the above depending upon the number of surgeons.

Specimen Job Plan – 10.5 sessions 7.5:3 split

Theatre 3.0
OPD/pre-assessment 1.0
MDT 0.5
Admin 1.0
Ward Round 1.0
Travel 1.0
SPA 3.0

Based on the above split then 6.2 consultants would be required.

On an 8.5 session DCC with 2 SPAs

Theatre 3.0
OPD 2.0
MDT 0.5
Admin 1.0
Ward Round 1.0
Travel 1.0
SPA 2.0

Based on the above then 5.5 consultants would be required.

We do not know the number of sessions included in the current establishment of thoracic surgeons but we do know that the Welsh average is over 10 and the average number of SPAs is less than 3.

Covering the MTC from April 2020

As stated the planned go live date for the MTC is April 2020. It is not expected that the thoracic surgical centre will be established for around 2 years as capital infrastructure is required.

There is a clear level of anxiety about how the thoracic work will be covered at the MTC from April 2020 especially given that the trauma teams and the resuscitative surgeons may not be experienced in working in an MTC. Additionally the majority of work for thoracic surgeons in an MTC is rib fixations. It is suggested that similar to other centres, rib fixations can be undertaken by

orthopaedic surgeons. However it is recognised that this will take some time to become practice at the MTC and that thoracic surgeons are likely to be required to undertake the rib fixations in the short term.

Given all this the recommendation is that an additional locum thoracic surgeon is appointed at UHW for between 6 and 12 months in the first instance, to provide additional support from April 2020 and that the two thoracic consultant teams develop plans to work together. During this time where there are regular reviews of the emergency activity levels.

The advantage of this recommendation is that the MTC is better supported and that during the period that the locum is in place some of the assumptions in this paper can be tested especially regarding the need for a thoracic surgeon to attend the MTC in an emergency. It will also allow the thoracic surgery implementation group to complete its work on the model and will then allow a further discussion at Joint Committee on the long term model including consultant workforce when the implementation business case is presented.

Cost of additional locum – this is estimated to be in the order of £150,000 including on-costs, travel, intensity allowance etc.

Recommendation

To note the analysis and that this would draw the conclusion that the number of thoracic consultant surgeons required for the workload is around 5.5 to 6.2 wte consultants required depending upon exact job plan and DCC/SPA split.

To note that the amount of operating time is the crucial driver and that for the predicted activity (outturn plus 20%) 6.25 lists will be required every week. To enable every surgeon to have one full operating list this means that around 6 surgeons will be required.

Given the low probability of the surgeon being required to attend the MTC and the thoracic surgery centre at exactly the same time that there should be one call rota.

In recognition of the concerns regarding support to the MTC when it opens in April 2020 that a short term locum consultant is appointed in UHW. This will not impact on the total recommended numbers of consultants but will enable support for the MTC and to test and build confidence in the system whilst the final service model is being determined. Also that during this time the two thoracic centres develop plans to work together.

Appendix 1

The Liverpool Thoracic Centre Model
(presented at Clinical Summit May 2019)

Information from the Liverpool thoracic centre was presented at the Clinical Summit in May 2019. It was noted at this meeting that for a population of around 2.8 million people Liverpool have

5.5 wte thoracic surgeons working on a team based approach

They operate on a hub and spoke model which supports 10 peripheral hospitals

Weekly Clinics with attendance in person by thoracic surgeon.

- All new patients travel to LHCH.

Weekly Lung MDTs:

- 4 major MDTs with direct attendance & cross cover.
- Others by VC.

- MDTs: High Risk cases MDT, Lung cancer MDTs and Specialist MDTs.

Trauma support

- Trauma centre is 7 miles away.
  - Self-sufficient and independent.
- Chest trauma cases -
  - Phone Thoracic Consultants directly.
  - Thoracic Surgeons only contacted after local decision to open chest has been made.
  - Occasionally have to go to site.
  - Clinic every Thursday am. Patients seen by MS.
- Rib Fractures delt by Orthopaedic Surgeons who are now self-sufficient.

Golden Jubilee Hospital Clydebank

This centre covers a population of around 2.2m people. They are currently advertising for a consultant thoracic surgeon to join their team.

They have 4 full time thoracic surgeons + 1 mixed practice. (their current advert is for a vacancy in their full time establishment)

They cover 9 MDTs

1:4 on call with prospective cover & part of trauma team with MTC in Glasgow

Addendum Following Consultation

To note that surgery is not the only cure for lung cancer as there are radiotherapy techniques that are also curative but recognising that surgery has the best 5 year survival rates.

Clarity that the proposal, subject to fully being agreed via the implementation group, is that each MDT is supported by 2 surgeons.

The MDT numbers for Aneurin Bevan are not correct.

Other Changes Recommended Following Consultation

The locum consultant should be appointed for 12 months and not 6 to 12 months.

Pwyllgor Gwasanaethau Iechyd Arbenigol Cymru (PGIAC)
Welsh Health Specialised Services Committee (WHSSC)

Thoracic Surgery Single Site Consultant Workforce Model

Consultation on draft Thoracic Surgery Single Site Consultant Workforce Model

Stakeholder comments table

14th June 2019

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
1.	Medical Director 1	2	21-23		The outturn + 20% is likely to be at the lower end of potential activity increase.	We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes.
2.	Medical Director 1	2	30-32		This advice and support could be provided virtually and without the physical presence of a thoracic surgeon.	This was agreed through consultation. However the interim model suggested would allow further evaluation of the demand and if needed reconsideration by boards in the future.

Appendix F

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
3.	Medical Director 1	4	14-15	Table 4	The figures across sites differ greatly reflecting both the case mix and the risk approach of individual surgeons. UK guidelines promote offering surgery to higher risk groups, so increasing resection rates. This stance needs to be encouraged in the single site model, properly supported by detailed patient discussion, full physiological assessment and with extensive pre-habilitation.	We agree. This is one of the opportunities of a new service and the presence of 2 surgeons in each MDT.
4.	Medical Director 1	7	1-10		Three session days are advantageous though would require careful job plan diary work to ensure adequate lower intensity clinical activities on preceding and following days. Three session days place extra pressures on theatre staff however and also potentially compromise time for training of junior staff.	The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation.
5.	Medical Director 1	7	15 et seq	Major Trauma Centre	The quoted and extrapolated figures reflect my experience in supporting major trauma. Additionally, the specific skills required in a thoracic surgical emergency context are straightforward and trauma surgeons can be instructed in these.	The external expert advisors supported your view.
6.	Medical Director 1	8	6-8		I would fully endorse this view.	Thank you
7.	Medical Director 1	10	4-17		I would fully endorse this view and for the reasons outlined	Thank you

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
8.	Medical Director 1	10	21-27		I would fully endorse the view that 6 thoracic surgeons wold be the acceptable number to provide a comprehensive thoracic surgical service for the relevant population.	Thank you
9.	Consultant Respiratory Physician 1	2	30		Is this a realistically a good use of a consultants time, 9-5 delivering advice and "waiting" for something to happen. This needs more robust thinking as to how the clinician would function in UHW if required to be there.	This was agreed through consultation. However the interim model suggested would allow further evaluation of demand and if needed reconsideration by boards in the future.
10.	Consultant Respiratory Physician 1	4	6		Surgery isn't the only cure as there are radiotherapy techniques that have radical intent. However, it has the best 5 year survival rates	We agree and will correct this.
11.	Consultant Thoracic Surgeon 1	General			We are very excited to take part in this consultation and assist in shaping a single thoracic surgery centre of excellence for South Wales. In order to do that and provide Wales with an innovative, safe and sustainable single centre we would like to present our comments to the workforce model consultation.	Thank you

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
12.	Consultant Thoracic Surgeon 1	3	25		Although the estimated amount of activity is calculated to be 1300 per year, we estimate it to be at least 1500 cases, (so 30% of current activity as presented in the thoracic clinical summit), taking into consideration the predicted increase of activity due to lung cancer screening in Wales (10-20% Manchester experience), the 2019 NICE guidelines that will increase the cohort of the operable patients and the predicted increase of activity due to awareness campaign by public health wales. We should also take into consideration the discussed and agreed need to increase surgery for benign disease (Estimated 100-150 new patients)	We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will therefore suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
13.	Consultant Thoracic Surgeon 1				In order to accommodate the above needs, we will need 2 theatre rooms available every day, working 8am - 5pm (as per England's specification) corresponding to 3 DCC because they include preoperative and postoperative management of the patients. A long 12 hours list is neither acceptable nor recommended as it impacts on all staff and their work-life balance and creates recruitment and retention issues. 12 hour thoracic list in Morriston is done only because of lack of theatre capacity and it's against any accepted practice. This could have a negative impact on patients' safety.	The RCS review recommended this was the optimal model. This can be revisited during implementation. The implementation group is identifying theatre requirements and current planning is based on two as described at the Clinical summit in March although this will need to be finalised. The exact operating times will need to be agreed with the surgeons at implementation to achieve the greatest efficiency balanced with workforce well-being considerations.

14.	Consultant Thoracic Surgeon 1				The proposal of 6 theatre days per week is inadequate as it is below the present theatre availability. Presently in UHW, we have 4 theatre lists per week and we additionally covered 34 extra theatre lists and cross covered 28 lists (leave). That corresponds to 5 theatre lists per week. Despite this we still have long waiting lists and breachers. Morriston has 2 long lists per week and a regular waiting initiative list on Saturdays. This corresponds to 3 theatre lists per week. Overall between UHW and Morriston presently we have access to 8 theatre lists. According to our calculations of 1500 cases per year and 2,5 cases per list we would need 10-11 lists weekly.	The suggestion in the paper is that each theatre list is 3 consultant sessions ie 3 x 3.75 hours. This was based on current practice at one of the centres. Regardless of how lists are configured there is a need to deliver 1100 procedures currently, rising to 1300 in line with 20% increase that is being used for planning purposes. This may rise in the future as you suggest and we will constantly keep this under review as we would for any of our commissioned services. Our external advice suggests that for the number of primary lung resections that are currently being undertaken in south Wales and allowing for a 20% increase then 6 surgeons would give sufficient operating time. Their view was that increasing this number based on current and 20% projected increase would be at the margins of acceptable operating numbers per surgeon. We acknowledge that if lung cancer screening is introduced (estimated to be at least 3 years away) then the number of primary lung resections may increase and should this happen we will review the number of surgeons required.
15.	Consultant Thoracic Surgeon 1				We believe that it's unsafe and against current guidelines (Major Trauma Centre specification, GIRFT	Our external advice (see separate appendix) says that GIRFT is opinion rather than

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
					report) and recommendations to provide cover from a 42 miles distance.	evidence based guidance and the advice from professional bodies is more relevant. The advice from the SCTS is that given the rare need for a thoracic surgeon to attend the MTC in an emergency then it is not a good use of resource to appoint additional consultants simply to cover this rare event. The clinical Lead for Major Trauma Networks in England also supported this view. We recognise however that support to the MTC when it opens in April 2020 is of significant concern and that is why we are recommending the appointment of a locum thoracic surgeon at UHW from April 2020 to provide this support and to develop and test the system so that we have much greater clarity on the requirements and we recommend that the workforce model is re-assessed prior to the thoracic surgery centre opening.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
16.	Consultant Thoracic Surgeon 1				The appointment of the 4th consultant will be essential to facilitate 1 in 5 on call rota and maintain the high-quality patient care and outcomes during this transitional period. This would require investment in infrastructure as additional ward beds, outpatients' clinic, theatre equipment, secretarial support and two additional theatre lists would be essential. It should be advertised as a locum for 6-12 months initially with view to substantive post. This would make the post attractive and would make recruitment easier in view of shortage of thoracic surgeons in UK. This transitional phase with 4 consultants in UHW would allow us to prospectively evaluate the needs of the MTC and Thoracic services in general.	We agree that an interim appointment has many advantages. We are however unable to commit to the job description without agreement with the provider organisation.
17.	Consultant Thoracic Surgeon 1				The appointment of the 4th consultant would be ideal if infrastructure can be provided. If not available, we respectfully propose that the two surgeons from nearby centres provide cover for 2 in 5 days of on call. This would help evaluate the feasibility of providing an on call service for the MTC from a distance.	We agree and have suggested that both options are developed.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
18.	Consultant Thoracic Surgeon 1				As a centre of excellence we should cover all the specialized MDTs such as interstitial lung disease, mesothelioma, COPD, chest wall deformities, sarcoma, metastatic (G.I.) etc. There was also the recommendation that we have 2 surgeons per MDT which doesn't reflect on the document. The need for high risk MDT/second opinion was also emphasized in many occasions including our recent thoracic workshops. This should be weekly with attendance of all the consultants.	Apologies if the document was not clear, the intention is that there are 2 surgeons covering each MDT. The cover for specialised MDTs will need to be agreed as part of implementation. Additionally advice from the Welsh cancer Network suggests that the number of MDTs could be rationalised from that suggested in the paper although they welcome the model of 2 surgeons/MDT.
19.	Consultant Thoracic Surgeon 1				PAs are not calculated correctly in the WHSCC proposal, since they don't include on call supplement, correct number of MDTs ,theatre sessions and outpatient clinics, and the presence in UHW from 9-5. In the proposal from WHSCC, the activity is even lesser than the current one. Proposed revised level of activity for the single Thoracic surgery centre is provided below.	This raises questions as to how the current service can be delivered and does not bench mark with any other centre in the UK.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response

Activity	Per Week	Total sessions per week
Theatre sessions	10 x 3 DCC(8am -5pm)	30
Pre assessment and outpatient clinics	**-**Morriston daily 6 per week -LLandough 1 per week UHW 1 per week -Gwent 1 per week -WEST SOUTH WALES MDT**?**	9 + west south wales
MDT	6 x 2 (2 surgeons per MDT) High risk MDT(6 X 0.5) 6 specialised MDT(monthly)	6 3 1.5
On call	1 in 6 (1-2 according to amount of work required)	6-12
Travel	5	5
Ward rounds	6	6
Admin	6	6
UHW 9-5 cover	10	10
Cross cover clinic and theatre	?	?
Total		**83.5 – 89.5 ?+**

Appendix F

CONFIDENTIAL Comments forms with attachments such as research articles, letters or leaflets were not accepted

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
20.	Consultant Thoracic Surgeon 1				15 sessions are required per week for UHW 9-5 cover without calculating cross-cover.	Questions have been raised during this consultation on the need for 5 day cover at UHW. However it is acknowledged that this was part of the original considerations by Boards. Cover at UHW is however not expected to be additional to out-patients etc. If surgeons are based at UHW it could reasonably be expected that they would be doing some type of activity – out-patients, preassessment, admin, MDTs etc.
21.	Consultant Thoracic Surgeon 1				In conclusion for a single centre to excel we will need at least 10-12 theatre lists per week and a service equivalent to 83-89 PAs at a consultant level. We should not embark on a centre of excellence with suboptimal provisions.	These calculations do not bench mark with any other centre in the UK.
22.	Trauma Network	1	38	Backgro und	Needs to include the NHSE quality indicators and service specification for major trauma services.	Accept that the Trauma Network should be delivered based on recommended standards. Joint Committee at its meeting in March 2019 however confirmed that a phasing of standards was expected. The expert advice on the models and requirements in England is provided in appendix G.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
23.	Trauma Network	2	24	Background	This is part of the trauma team and has a limited application. It is not a substitute for having a thoracic surgeon for performing an Emergency Thoracotomy in theatre.	We discussed this with external advisors including the Clinical Lead for Major Trauma in England and representatives from the SCTS. Their advice and comments are provided in Appendix G but to summarise their advice was that the need for a thoracic surgeon to attend the MTC in an emergency would be rare and as such recruiting additional surgeons to cover this eventuality would not be a good use of resource nor would the jobs be attractive and we would be unlikely to recruit to such posts.
24.	Trauma Network	2	36	Background	This is not the case. The presence of a trauma surgeon is not a replacement for the presence of a thoracic surgeon	See the comments above.
25.	Trauma Network	7	16	Major Trauma Centre	This may well be a driver, but WHSSC should recognise as the principle commissioning body for the MTN that South Wales is the only region in the UK, where funding has not been secured for a MTN. South Wales is the only outlier and this poses significant clinical, strategic, reputational and political risks.	The need for an MTN has been recognised by WHSSC.

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26.	Trauma Network	7	19	Major Trauma Centre	This needs further clarification and should be edited as follows – "estimates from providers in NHSE indicates 2-5 cases/year for Resuscitative Thoracotomy and 5-8 cases/year for Emergency Thoracotomy. In total 7-13 cases, which may potentially require intervention from a thoracic surgeon. This is more comparable with UHW data.	We will note based on your advice. The Clinical Lead for Major Trauma in England suggested that there would be likely to be a requirement to attend the MTC at UHW in an emergency around 4 times/year based on experience in his own trauma centre. However our recommendation is that an additional locum surgeon is appointed at UHW from April 2020 and this will allow the need to be tested and we recommend that the workforce model is re-assessed in the months prior to the thoracic surgical centre go live date.
27.	Trauma Network	7	22	Major Trauma Centre	The information contained in comment number 5 is more in keeping with the lower end of the obtained English data. Ultimately changes in patient flow with the development of the MTN will be accurately captured in year 1 (TARN dataset) and visible to WHSSC to give a much more informed picture. However, see caveat under comment number 8.	We propose that the interim model will allow formal assessment.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
28.	Trauma Network	7	25	Major Trauma Centre	I am not convinced that you can base the analysis on data that is based 16-year-old data – the incidence of penetrating trauma has increased in that time. Again, changes in patient flow with the development of the MTN will be accurately captured in year 1 (TARN dataset) and visible to WHSSC to give a much more informed picture. However, see caveat under comment under 8 (*comment 29 in this table)*.	The advice we have taken supports the analysis that this would be a rare event. However we support your view that this needs testing hence the recommendation regarding the appointment of an additional locum surgeon.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
29.	Trauma Network	10	4	Covering the MTC from April 2020	The appointment of locum consultant for 6-12mths based at the MTC is welcome and will allow the MTC to go live next year from a thoracic cover perspective. The risks of not establishing the MTN next year are significant and cannot be justified based on the current impasse. However, the assessment needs to include some information on the chances of successful recruitment to a locum post over a substantive post. The paper states that it will be around 2 years until centralisation occurs, so a 2- year appointment would be sensible. Data on activity cannot be determined accurately over 1 year – variation exists year by year and therefore a longer period would be required to assess activity. In the event that this post is unfilled, the current impasse will continue. Recruitment into a substantive post will be more attractive and could invite the opportunity to appoint a lead surgeon to take forward the service change. Whilst this may exceed the total number of recommended consultants, it serves to bring a number of other advantages.	We have been informed that there is a potential locum candidate. The advice we have been given is that the amount of operating is the crucial factor in successful recruitment and if there is unsufficient operating available this would have a detrimental effect on ability to recruit as the job would be unattractive,

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
30.	Consultant Medical Oncologist	4	6	Primary lung resections	It isn't true that "Surgical resection is currently the only curative option for lung cancer". Series show an 11% 10 year survival for chemoradiotherapy in inoperable tumours. It is accepted that the highest cure rates come from surgery.	We agree and will correct
31.	Consultant Medical Oncologist	5	12	MDTs	Could add that the lung cancer services are due to be peer reviewed in Q3 2019	Point noted thank you and explored with the Welsh Cancer Network. The peer review will be useful to inform the implementation process.
32.	Wales Cancer Network	3	24/25/26	Demand Analysis	These figures do not consider the requirement of the Single Cancer Pathway in Wales and implementation of National Optimal Pathway for lung cancer. Surgical treatment will need to be performed within a maximum of 62 days from point of suspicion, ideally treating within 49 days. Evidence in recent studies indicate delaying surgery beyond 37 days from diagnosis leads to a worsening of long term overall survival (Yang et al 2016)	We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will therefore suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
33.	Wales Cancer Network	3	24/25 /26	Demand Analysis	These figures do not factor the recent international evidence for low dose CT screening for lung cancer in a high risk population (targeted lung health check programme). NELSON (as well as other trials) presentation data suggests a 50% increase in surgical resection numbers following implementation of a target health check programme.	See above
34.	Wales Cancer Network	6	6-7	Table MDTs	While this table uses 2015 'new referral' numbers and Table 4 2018 uses 'total cases' numbers I presume these should be roughly the same. However, when looking at the table on this page the total added numbers do not correlate e.g. ABUHB =257 although Royal Gwent/Neville = 268 + 106	The referenced year in each of the two tables is different, hence the numbers are different.
35.	Medical Director 2	General			The field of lung cancer and requirements for the management of patients with lung cancer may change in the next few years for example if lung cancer screening is adopted in Wales and the approach to workforce model considerations and arrangements needs to allow some flexibility	We agree, however it is difficult to predict when this will happen and currently activity is relatively stable. We will therefore suggest a further assessment 6 months pre implementation and ongoing review as normal part of WHSSC processes

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
36.	Medical Director 2	General			There is likely to be a different requirement for thoracic surgery input during the initial year or so of the MTC becoming operational (ie whilst orthopaedic surgeons are trained in rib fixation etc) compared to when the MTC is established.	We agree and that is why we propose an interim arrangement
37.	Medical Director 2	General			The actual activity of the proposed thoracic surgeon based at UHW in the daytime when the MTC is established would need to be specified clearly as there is a risk that activity could be minimal if it only involved input for patients with complex major trauma.	This was agreed through consultation. However the interim model suggested would allow further assessment and if needed reconsideration by boards in the future. See also response above.
38.	Medical Director 2	General			The establishment of a single site thoracic surgery centre is extremely important for our population and for South Wales, as is the establishment of the Trauma Network and the MTC. Both are long overdue for Wales, and there is likely to need to be a degree of compromise to ensure that progress on both programmes of work are not delayed.	We agree

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
39.	Consultant Thoracic Surgeon 2	2	16 to 17	MTC	Agree that the location of the MTC had not been determined at that time. However, the RCS clearly stated that Thoracic Surgery does not need to be at the same site as the MTC. This was known to UHW, Cardiff at the time of their bid for the MTC. Did they give plans on how the UHW Health Board would arrange Thoracic surgery cover for the MTC if thoracic surgery were to move to Swansea?	This is outside the scope of this paper
40.	Consultant Thoracic Surgeon 2	2	21, 22,		Do not agree and will not support …all 6 surgeons being involved with "onsite cover" for UHW site. For a fair equitable service across South Wales the surgeon covering the UHW lung MDT should be the surgeon available to cover UHW once a week as is the practice at Liverpool Heart and Chest Hospital (LHCH) for the MTC there.	Point noted. The exact job plan configuration would need to be agreed at the implementation stage. The working assumption however is that the thoracic surgical team will operate as 1 team and will cross cover to deliver the service model.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
41.	Consultant Thoracic Surgeon 2	2	30, 31		Do not agree and will not support …surgeons providing a thoracic surgery "presence" at UHW 5 days a week for advice and support (but will back 5 days a week on call telephone support for advice). Comment: This is totally unfair on hospitals in other Health Boards. May be ok for a physician but for a surgeon is a complete waste of time. Time that will be better spent in theatre ensuring timely surgery for cancer and other patients.	This was agreed through consultation. However the interim model suggested would allow further assessment and if needed reconsideration by boards in the future. Also see response above.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
42.	Consultant Thoracic Surgeon 2	2	36 to 39		Strongly agree and fully support that trauma surgeons appointed at MTC Cardiff are trained and able to practice independently for injuries to the thorax. A positive step in making the MTC Cardiff an independent, self-reliant flag ship specialty and not dependant on help from elsewhere (for example, Swansea or Bristol). An "on site on call thoracic surgeon" may not necessarily be available immediately but a thoracic trained trauma surgeon will be immediately available. Appointing an interested thoracic surgeon who is also trained in trauma (Thoraco-Trauma Surgeon) as a member of the trauma team will help him/her support and train the team and colleagues. This may give an opportunity for any current thoracic surgeon not wishing to move to Swansea a chance to stay back at UHW Cardiff and be part of the Major Trauma Team.	Thank you

43.	Consultant Thoracic Surgeon 2	3	11, 12		(Instead of "the full range") Should read as, "Surgeons on the rota should be able to deal with "**a"** range of thoracic surgical emergencies, **excluding** oesophageal injuries, which will be dealt by upper GI surgeons, great vessel injuries, which will be dealt by cardiac surgeons, Tracheal neck injuries, which will be dealt by ENT surgeons and paediatric injuries, which will be dealt by the MTC at Bristol. Help from allied specialties, for example, ENT and cardiac surgery for thoracic tracheal and hilar injuries will be required as patients may have to be placed on cardio-pulmonary bypass to deal with these extremely rare situations. Paediatric cardiothoracic trauma will be dealt by MTC Bristol. COMMENT: It is highly important for the UHW Cardiff Health Board, which is demanding an on site Thoracic surgery cover, to seriously consider the fact that Thoracic surgeons currently working in South Wales do not meet this requirement of "…able to deal with a full range of thoracic surgical emergencies." They either have no experience or very little experience in dealing with such injuries in the past 10- 15 years. It is unsafe and unreasonable of the UHW Health Board Management to expect from thoracic surgeons in this disposition to attend to and deal with major thoracic injuries in a completely	Point noted. The expert advice suggested that there were a range of professionals who could and should support thoracic surgical emergencies dependent upon their nature. This was agreed through consultation. However the interim model suggested would allow further assessment and if needed reconsideration by boards in the future.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
					alien theatre or emergency room environment and work with an unfamiliar trauma team staff safely. It is much better and a unique opportunity for the UHW HB Management team to embrace the proposition of training the MTC Trauma Surgeons to deal with such emergencies (ref page 2 line 37 and 38), and help develop an independent, self-reliant, highly skilled Trauma Team making the MTC at UHW a flag ship MTC for the UK. There will be a 24/7 thoracic on call telephone back-up support for advice from the Single Thoracic Centre at Swansea.	
44.	Consultant Thoracic Surgeon 2	3	13, 14		Training the Trauma surgeons or appointing "Thoraco-Trauma" surgeons by the MTC Cardiff as described above will help address this.	We agree
45.	Consultant Thoracic Surgeon 2	5	6,7	MDTs	Some MDTs will have to merge. Support of the chest physicians and the cancer network will be essential to achieve this, so that there are 6 major MDTs across South Wales. The table is a guidance and combinations can change to make the cover practical. However, it will be important to ensure that for each surgeon there is equity of number of new cases discussed at each MDT.	We agree and this point has been supported by the representative from the Cancer Network who suggested that the number of MDTs should be no more than 6 but could potentially be fewer.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
46.	Consultant Thoracic Surgeon 2	6	25	Prehabilitation	COMMENT: To add that the prehab service will work with thoracic nurses, allied health practitioners, dieticians, Macmillan nurses, pain team etc to help the single centre provide a complete package of holistic care to patients along the entire patient pathway.	Point noted.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
47.	Consultant Thoracic Surgeon 2	7	3, 4,5	Operating Lists	Taking into consideration that the single centre will be a teaching centre and following LHCH model, the most efficient way to run theatres will be "a minimum of" one full day and one half day per surgeon with 3 cases per full day list (two long and one short) running from 8:00am to 6:30 pm (including post op care). An ideal model would be two theatre days per surgeon per week. EVIDENCE: Taking into consideration future impact of lung cancer screening and expected increase in number of lung resections, the centre will be expected to perform ~1300 cases per year. Dividing this by three cases equals 433.3 cases. Over 50 weeks per year this works out to 8.6 lists per week. Taking into account cancellations due to theatre staff sickness, bank holidays, audit days, Hospital Infections, etc., = 10 lists per week or 2 theatres running 5 days a week for elective and emergency work is what it will take to provide timely high standard of surgical care to patients and training to future surgeons and staff.	The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation. There are clearly a range of views (see comments above) and the exact configuration will need to be agreed as part of implementation taking into consideration optimal efficiency and staff well-being.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
48.	Consultant Thoracic Surgeon 2	7	15-40	MTC	Brilliant piece of work – shows the reality of the situation! Shows that having a surgeon on site 5 days a week at UHW provides miniscule patient care if any, and is a complete waste of money and time.	Point noted.
49.	Consultant Thoracic Surgeon 2	8	13	Required Consultant Workload- Theatre sessions	Theatre sessions per week 6.5 is not adequate. Minimum 8.6 x4 sessions per week EVIDENCE: As demonstrated above under "Operating Lists"	See response above.
50.	Consultant Thoracic Surgeon 2	9	5-12	Job Plan	…7.5:3 split then "6.2 consultants would be required." EVIDENCE/COMMENT: theatre sessions per surgeon required = 4 and NOT 3.0 as described under "Operating Lists." Also job plan in SBUHB Wales is 7:3 with 3 SPAs for each consultant. Unlike NHS England where each session is 4 hours long, each session in NHS Wales is 3 and a half. So cannot compare work covered by NHS England consultants with NHS Wales's consultants. The RCS and NHS England thoracic surgeons should be always made aware of this when obtaining any consultation regarding job plans, theatre lists etc from them.	Points noted however the advice we have received is that 6 surgeons is sufficient to cover the anticipated thoracic surgical workload. Comparison with other centres also support 6 surgeons as being sufficient.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
51.	Consultant Thoracic Surgeon 2	9	8	MDT	Disagree with MDT 0.5 EVIDENCE: DCC does not take into account other specialist MDTs that will need cover. For example, Sarcoma MDT; Interstitial Lung Disease MDT; Mesothelioma MDT; Colo-rectal MDTs per Health Board; Emphysema-LVR MDT; Radiology MDT; Base hospital Specialist MDT.	Point noted. This was based on the advice we received from other centres. This can be reviewed.
52.	Consultant Thoracic Surgeon 2	9	14		COMMENT: Based on the above split then a minimum of 7.3 consultants would be required. Eliminating UHW MTC cover every week (which is a complete waste of good money, time and does not make any sense whatsoever) will bring the number of consultants required to ~6 consultants.	Point noted.

53.	Consultant Thoracic Surgeon 2	10	19, 22	Recommendations	Disagree with, " ..workload is around 5.5 to 6.2." Should read, " minimum 6.5 to 7.5." EVIDENCE: As described above. COMMENTS- RECOMMENDATIONS: Each consultant covers two Lung cancer MDTs (visiting the main peripheral MDT and cross covering the second with V/C link); two clinics (visiting one peripheral clinic of the main MDT and servicing the second base hospital clinic for other MDTs and emergency work arising from on-call); minimum one full day and one half day theatre (ideally two lists per week); each surgeon covers one or two specialist MDTs; and 1:5 on call. Note: In the process of visiting the peripheral MDT and its clinic the visiting thoracic surgeon will face requests for advice and opinion from chest physicians and others and many times see inpatients, A&E trauma and other patients. This will take up DCC time. This has not been considered. EVIDENCE: First-hand experience when working for Birmingham Heartlands Hospital, Southampton and the Royal Brompton Hospital. Visiting peripheral MDTs many times involved seeing patients in the ward, ED for opinion and management.	Point noted and see response above. Benchmarks from other centres and the advice we have received suggests that 6 surgeons is sufficient. This can be tested and re-assessed however prior to implementation.

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54.	Consultant Thoracic Surgeon 2	9	19	OPD	**All surgeons will NOT provide UHW onsite cover**. This should be provided by the surgeon covering the UHW Lung MDT and its clinic once a week as is done by Mr M Shackcloth once a week at Liverpool Heart and Chest Hospital for the MTC there. It is mandatory that patients from all of South Wales Health Boards covered by the Single Site Thoracic Service at SBUH receive a fair and equitable service. UHW Cardiff should not get any preferential, special treatment – No post code lottery care!	Please see response above.
55.	Consultant Thoracic Surgeon 2	9	40,41	MTC work	Totally agree. This can and should be dealt by Trauma and Orthopaedics as is done at LHCH.	Thank you
56.	Consultant Thoracic Surgeon 2	FINAL COMMENT			Thank you for your hard work.	Thank you
57.	Health Board CEO 1	1	8	Context	Each of the Welsh Health Boards considered the WHSSC recommendation and agreed this subject to a number of conditions being met.	Point noted.
58.	Health Board CEO 1	1	14		It would be useful to make clear that the two medical directors provided the paper as requested by WHSS (letter dated 28th December 2018 from Sian Lewis to Dr Shortland and Dr Evans).	Point noted and is reflected in the conclusions in the Joint Committee paper.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
59.	Health Board CEO 1	1	19		The matters and uncertainties referred to should be included.	They are included in the Joint Committee paper
60.	Health Board CEO 1	1	24 25		The establishment of an Expert Panel does seem at variance with the timing of the Consultation document.	We were constrained by the very tight timescales
61.	Health Board CEO 1	1	37-38		There should be a note that neither of these documents include support required for an MTC	Both the English and Welsh Service Specifications went to widespread stakeholder consultation. This was not raised in our consultation as an issue. It is only since the recommendation to locate at Morriston this has been raised.
62.	Health Board CEO 1	1	41		It would be helpful if the assumptions are made clear within the document	Apologies if this is not clear.
63.	Health Board CEO 1	2	16	Backgro und	It is important that the opinions of the RCS Invited Review are considered in the context that they were made prior to the decision to locate the MTC in a different Health Board to the site of the Thoracic Centralisation.	The RCS were aware of the work around the location of the MTC as were the Independent Panel
64.	Health Board CEO 1	2	39	Backgro und	We have been unable to find any reference within the Intercollegiate Surgical Curriculum Programme that describes surgeons being trained to "practice independently for injuries to the thorax". The curriculum describes training to include a subset of thoracic surgical skills, this does not equate to a mandate for independent practice.	https://www.iscp.ac.uk/static/public/Trauma_Surgery_TIG_Syllabus_2018.pdf

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65.	Health Board CEO 1	7	9	Operating lists	The calculation of 6.25 lists per week seems overly optimistic. C&V currently run 4 lists per week delivering 672 cases per annum. On a simplistic basis, the forecast activity of 1300 cases would suggest that circa 8 operating lists would be required per week.	See response above. The calculations were done on a long day and 4 cases per 3 sessions ie 11.15 hours. The operating hours at the two centres are different currently and the sessions are currently being calculated differently at both sites.
66.	Health Board CEO 1	3 7	7, 13-14		This guidance regarding emergency cover needs to be referenced from the source Cardiothoracic Surgery GIRFT Programme National Specialty Report 2018. Please can it be clarified that the specification does not deal with thoracic cover to an MTC	Point noted however please see response above regarding the status of the GIRFT report.
67.	Health Board CEO 1	7		Major Trauma Centre	There is no reference in this section to the NHSE standards for Major Trauma that have been agreed as the standards for commissioning in the Wales Trauma Network. The standards clearly document the need for a Cardiothoracic surgeon to be available within 30mins to attend a trauma patient and this is not reflected anywhere in the paper.	Point noted however the paper refers to cardiothoracic surgeons and the issue here relates to thoracic surgeons which needs to be emphasised. Please also see appendix G which gives detail on the advice we have received regarding thoracic surgeons need to attend the MTC in an emergency.
68.	Health Board CEO 1	7	19	Major Trauma Centre	Figures supplied by the existing thoracic Surgeons in C&V suggest this is an underestimate and the more likely volume is 5-11 p.a.	The development of an interim model will allow this to be fully assessed

Appendix F

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Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
69.	Health Board CEO 1	7	22	Major Trauma Centre	It would have been helpful if the centres providing these two varying opinions were clarified. Indeed it is most common in Cardiff and Vale that currently Thoracic trauma is most often managed by our Cardiac surgeons. This is not a sustainable position going forward as new and recent Cardiac Surgeons being appointed are not skilled in thoracic trauma. The GIRFT report specifically recommends ending the practice of using dedicated cardiac surgeons to provide emergency thoracic cover. Furthermore the SAC and SCTS UK Cardiothoracic Surgery Workforce Report 2019 describes increasing practice of splitting the specialty into cardiac and thoracic surgery	Please see appendix G which gives further advice from the SCTS and the National Clinical Director for Trauma for England.
70.	Health Board CEO 1	8	3	Major Trauma Centre	See comment 3 above The coverage of the MTC by a single rota from the surgical centre, when established, does not provide thoracic surgical cover consistent with the standards of a MTC and best practice.	Please see response above and the further advice in appendix G

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
71.	Health Board CEO 1	9	39	Covering the MTC from April 2020	The MTC has described the development of a tier of resuscitative surgeons within the existing workforce to cover the general surgical element of major trauma operating. We have not proposed that these surgeons are on an on-call rota to cover thoracic surgery as this would directly contradict the recommendations of the Cardiothoracic Surgery GIRFT Programme National Specialty Report 2018? The trauma team already have the skill to perform resuscitative thoracotomy (open the chest and perform a limited range of interventions). It is the arrangements beyond this that are of concern. It is not in the remit of the trauma team to go beyond these initial limited interventions and provide definitive thoracic surgery.	Please see response above.
72.	Health Board CEO 1	11	All	The Liverpool model	Based on the data presented at the Summit in May we have concerns about generalising the Liverpool experience to the WTN. The activity levels 2011-16 in UHW were significantly higher than Liverpool and it is only 7 miles away from its MTC. The description of trauma support to the MTC lacks meaningful detail.	Please see response above

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
73.	Health Board CEO 2	2	16-17	Background	The statement that "the location of the MTC had not been determined" should have been followed by a clarification that this materially affects the consultant workforce plans, particularly in regard to providing cover for 2 separate sites.	The advice we have been given is that the location of the MTC should not affect the consultant numbers.
74.	Health Board CEO 2	7	1-9	Operating lists	Current operating lists on each site average approximately 3 cases per list, which would equate to the need for 8-9 lists per week when job plans are annualised. The calculations of workload for surgery do not factor-in pre-operative and post-operative care.	The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
75.	Health Board CEO 2	7	16-40	Major Trauma Centre	The calculation of work associated with the requirement to cover out-of-hours 7 days/week 365 days/year fails to adequately recognise the burden of work at evenings and weekends: Firstly, the establishment of a single thoracic surgical centre on one site will substantially increase the probability of post-operative complications from elective cases which would require consultant input during evenings and weekends. Secondly, the stated infrequency of phone calls or call-outs in the out-of-hours period is immaterial in relation to the essential requirement – which is to be available immediately when requested. For the person who is on-call on any given day, the expectation is that they will be able to attend either unit in the event of an emergency and must therefore make adequate provision in their home/family lives in order to travel at any hour to the relevant site. This is a significant burden and not recognised adequately in the proposal.	The advice we have received is that the burden of out of hours work is low. We have also been advised that operating 2 rotas is neither desirable or required and would be difficult to recruit to.

76.	Health Board CEO 2	General			It is disappointing that the paper underestimates the volume of work and the challenge of providing consultant cover for the establishment of two high-profile and geographically separate services. We do not consider that 6 consultants would be able to provide this sustainably. The paper prepared by the Medical Directors, which might usefully have been included as an appendix in order to compare and contrast the different approaches, recommended a total of 8 consultants and made adequate provision for out-of-hours cover. We believe that a total of 8 consultants remains the most pragmatic solution to establish the service safely. The paper noted the requirement for 8 surgeons to adequately cover the MTC: "that the sessions are distributed as part of a wider group job plan amongst the new posts and all existing post-holder, to ensure equal distribution of workload supporting the MTC as well as tertiary activity. It is anticipated this would be accommodated with a 1 in 8 "hot" on-call covering the Thoracic Centre in Morriston Hospital and a separate quieter 1 in 8 on-call covering the Cardiff and Vale MTC at the University Hospital of Wales. This would mean an on call overall	We came to our conclusion regarding the optimal number of consultants based not only on mathematical modelling of the clinical activity but benchmarking with a range of providers across the UK. In addition we subsequently tested this model with the President of the SCTS and an expert panel of thoracic surgeons who are members of the SCTS who also support the conclusion.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
					of 1 in 4 and means there would not be a situation where either centre is not physically covered by a Consultant Thoracic Surgeon" The proposal is based on a tight mathematical calculation of sessions but leaves very little room for the eventuality that the workload is higher than anticipated and/or sessions cannot be practically worked as described. The proposal lacks a pragmatic perspective of the wider picture: that this is a shortage specialty; that it is more difficult to recruit to Wales; and that the current workforce is fragile. The existing Thoracic surgeons are currently highly engaged in the process and are actively contributing to the Thoracic workshops – this could easily be lost and would be difficult to retrieve.	
77.	Consultant Cardiothoracic Surgeon	General			Largely very supportive of the proposals but with the following comments:	Thank you

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
78.	Consultant Cardiothoracic Surgeon				The main issue is the basic activity plan on which the modelling is based i.e. 4 case per theatre list is unrealistic. The most efficient of list in either of the HB delivers just over 3 case prelist on an extended days working 8-630 theatre and quite often we struggle to get to 2.5 case per list – developing these calculation leads to consultant workforce between 6.5-7.5 surgeons.	The RCS review recommended this as the optimal model for efficiency. This can be revisited during implementation.
79.	Consultant Cardiothoracic Surgeon				The annual activity on the SCTS report would suggest annualised case throughput per surgeon of somewhere between 150+/-50 cases depending on the case mix developing this calculation would suggest that 8 surgeons would be needed especially if the MTS is to be supported between 9-5	This does not benchmark with any other UK centre and is not consistent with the advice we have been given. Please see responses above.
80.	Consultant Cardiothoracic Surgeon				Are we modelling on 42, 50 week per year of activity?	52 weeks per year with prospective cover which benchmarks with other UK centres.
81.	Consultant Cardiothoracic Surgeon				The need to upskill trauma surgeons at the MTC needs to be supported by the Consultant Thoracic Workforce	We agree and have therefore suggested an interim arrangement with an additional thoracic surgeon located at the MTC from April 2020.

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82.	Consultant Cardiothoracic Surgeon				Equity of access to surgical treatment for chest wall injury across the trauma network in south wales can best be delivered by chest trauma MDT bases approach where all significant chest wall injury cases are reviewed.	We suggest this should be looked at via implementation.
83.	Medical Director 3	1	39	Background	Also need to take into account the potential introduction of a targeted lung cancer screening programme in Wales - increase in number of patients with early stage disease treated by surgery	We have discussed this with the representative from the Cancer Network. Lung cancer screening is unlikely to be introduced for another 3 years and as we do with all other commissioned services, we will review any activity changes regularly.
84.	Medical Director 3	2	22	Background	Only 2 OP clinics per week proposed on this site, so not sure what the consultants are going to do with the rest of their time?	This point has been noted.
85.	Medical Director 3	4	6	Demand Analysis	Cure can also be obtained from treatment with radical radiotherapy	Point noted.
86.	Medical Director 3	5	6 (Table)	MDTs	411 patients within ABUHB in 2015	Point noted. We will amend the figures.
87.	Medical Director 3	6	1 (Table)	MDTs	Requires recalculation to 722 - significantly more than any other pair of surgeons, which may place ABUHB at a disadvantage	Point noted. Information was based on that presented at the March clinical summit. The distribution between the surgeons will need to be amended as part of the implementation process.
88.	Medical Director 3	6	23	MDTs	Anticipate no change to weekly surgical clinic at RGH	Point noted.

Comment number	Name of stakeholder organisation / individual	Page No.	Line No.	Section	Comments	WHSSC response
89.	Medical Director 3	8	13	Required Consultant Workload Total number of Sessions /week	Why daily at Morriston if patients are to be seen closer to home - could there not be a pre-assessment service in Cardiff?	Accept this point and this would be the aspiration but we are advised will depend upon the availability of anaesthetists.
90.	Medical Director 3	10	5	Covering the MTC from April 2020	Clarification is required as to whether this is a 4th surgeon at UHW	Yes that is the recommendation to support the concerns being expressed regarding the MTC.
91.	Medical Director 3	10	27	Recommendation	Does this take into account speed of access? The National Optimal Lung Cancer Pathway requires surgery with 21 days of decision to treat.	In discussion with the representative from the Cancer Network this suggested number of surgeons and anticipated activity does take this into account.

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Thoracic Surgery Consultant Work-force Model Expert Advice.

Teleconference 18.06.19

Attending:

Chris Moran, NHS England National Clinical Director

Rajesh Shah, Clinical Lead for Thoracic Surgery Manchester NHS Foundation Trust, Chair of the Specialty Advisory Committee on Training and co-opted member of the Society of Cardiothoracic Surgeons (SCTS) Executive Committee.

Juliet King, Thoracic Surgeon, Guys & St Thomas NHS Foundation Trust, member of the SCTS Thoracic Committee

Steve Woolley, Thoracic Surgeon, Liverpool Heart & Chest Hospital, Co-chair of Thoracic Committee, SCTS and co-opted member of SCTS Executive Committee

Sian Lewis, Managing Director, WHSSC

Karen Preece, Director of Planning, WHSSC

Background:

Members of the panel were each provided with the consultation document in advance of the meeting and further background information was provided by Karen Preece at the start.

Below is a summary of the discussion organised into themes rather than a chronological summary of the discussion.

1. **Clarity on the interface of thoracic surgeons in the immediate management of trauma patients:**

There was unanimous agreement amongst the thoracic surgeons present that the Getting it Right First Time (GIRFT) review 2018 recommendation that thoracic trauma should only be covered by thoracic surgeons and not by cardiac surgeons reflected an opinion and did not have an underlying evidence base. They expressed the view that the professional perspective of the SCTS which is that surgeons on the Trauma Team should have training and the competence to perform resuscitative thoracotomy in ED or the operating theatre and that both cardiac and thoracic surgeons are competent to stop bleeding within the thorax, was more relevant.

There are just over one hundred thoracic surgeons in the UK. There are 22 Major Trauma Centres for adults in England, 1 in Northern Ireland and proposals for 3 in Scotland and 1 in Wales. It is highly unlikely that 100 surgeons will be able to provide comprehensive thoracic trauma care for 27 MTCs in the UK, either in the short or medium term. Thus, suggested by GIRFT cannot be delivered. The position of the SCTS is therefore that a pragmatic approach should be taken to providing cover by trained cardiac and thoracic surgeons.

The **Chair of the SAC** noted that the current training programme means that both cardiac and thoracic trainees have the competency to manage emergency thoracic trauma and all existing consultants should have this competency. If they do not then they should be offered the opportunity of further training.

He suggested there were 2 models of care for emergency thoracic surgery, first resuscitative trauma surgeons, secondly, on-site cardiac or thoracic surgeons if present. He emphasised again both cardiac and thoracic surgeons should be competent and stated that dual cover was not a good use of resources. His view was that thoracic trauma requiring immediate surgical intervention was rare and that this was best managed by resuscitative trauma surgeons with input from onsite cardiac or thoracic surgeons for the very rare event when additional support is needed. He noted there is a wide variation across the UK in models of cover and highlighted that Brighton was a MTC with no thoracic surgeons and only cardiac surgeons. He emphasised there was no single right answer and suggested we request sight of the draft guidance from the SCTS on the management of thoracic trauma. (***Paper requested; not yet available)***

The **National Clinical Director (NCD) for Trauma in England** explained that the commissioning standard in England was that MTCs have the capability within the Trauma Team to undertake resuscitative thoracotomy and that cardiac and thoracic surgeons were not part of the Trauma Team (available within 5 minutes) but should be available within 30 minutes to attend an emergency case. There are a number of working models in England with some MTCs having both cardiac and thoracic surgery on site and others having cover from a separate hospital site. The requirement for resuscitative thoracotomy is rare in MTCs that mainly deal with blunt trauma (as is the case in south Wales) and he estimates four times per year for the south Wales population.

The Co-chair of the SCTS Thoracic Committee noted that the one of the centres in the UK with the most experience of penetrating trauma injuries was Kings College Hospital in London and that in this centre support was provided by cardiac surgeons. This model works well there as they have no on site thoracic cover.

The member of the SCTS thoracic committee noted that the way in which cardiothoracic trauma is covered in the UK is variable, and likely to change further as cardiac and thoracic services become independent of each other. However in setting up the new South Wales service it would be important to have clear local guidance and rostering as to who is contacted in the event of major thoracic trauma where specialist intervention may be required. She believed that this would not necessitate a thoracic surgeon being on site at the MTC.

2. **Clarity on the interface of trauma surgeons in managing trauma patients with other specialties:**

Rib fracture fixation is rarely required as an emergency procedure within a few hours of injury but MTCs need the capability to provide this operation within 48

hours of the decision to operate. It must be performed by surgeons competent in this technique. Ideally, the service is provided jointly by thoracic and orthopaedic surgeons but this service may be provided by thoracic surgeons alone or by orthopaedic surgeons as long as thoracic surgical advice and back-up is available. All three models are in service in the UK with successful outcomes. Given the service requirement and geographical separation, the provision of rib fracture surgery by trained orthopaedic surgeons with back-up from the thoracic surgeons may be the best service model for South Wales.

The member of the SCTS thoracic committee suggested that providing an on-site thoracic surgeon at the opening of the MTC offered a fantastic opportunity for training and development of trauma and orthopaedic teams. She emphasised the importance of support for poly-trauma patients and that regular trauma ward rounds from thoracic surgeons would be important when services were centralised at Swansea. She felt this could be undertaken to coincide with clinics being held at UHW. It would be very important to ensure that onsite out of hours cover is provided at Swansea and that robust rostering should be made explicit in job plans.

The **NCD Trauma in for England** said that it is a pre-requisite in England that trauma teams have the capability for resuscitative thoracotomy and thoracic surgeons have a role to support this training.

3. **Expert advice on the level of activity required to maintain a consultant surgeons skills:**

The SAC Chair stated that thoracic surgeons need at least one full day operating time and that the evidence is that the greater number of operations the surgeons undertake, the better the outcomes. He felt that 8 surgeons would mean that the operating time for individual surgeons would be too low. In addition it would not represent a good use of resources. He suggested it might be a problem to recruit into such a post.

The member of the SCTS thoracic committee explained that a thoracic surgeon needs to undertake at least 50 primary lung resections per year and in her view 8 surgeons would mean this target may be difficult to meet. This view was supported by the Co-Chair of the SCTS Thoracic Committee. Although planning predicts a 20% increase in activity it is not clear at this stage whether this will mean a significant increase in the primary lung resections.

4. **Development of indicative job plans for consultant thoracic surgeons**

The member of the SCTS thoracic committee noted that 6 surgeons represented a "good number" and would allow sufficient time for Supporting Professional Activity sessions (SPAs).

The **Chair of the SAC** confirmed that in his centre there were 6 thoracic surgeons for a population of around 3.2 million.

There was agreement by **all thoracic surgeons** present that on current activity 6 surgeons represented the right number however there should be a further assessment if activity changes for example due to lung cancer screening.

There was discussion around the likely volume of out of hours work at the future single centre. The consensus was that this depended on adequate theatre capacity and if this was in place then semi-elective surgery would take place within working hours and there would be relatively little out of hours work. The **Chair of the SAC** advised that operating two rotas was unnecessary and not a good use of time, emphasising that well trained trauma surgeons or cardiac surgeons were competent in stopping bleeding.

Summary:

Chris Moran NCD for Trauma NHS England noted the discussion had been very helpful for him as MT Lead and summarised as follows:

1. The professional advice is that 6 thoracic surgeons is the right number
2. Trauma Teams must have the capability to perform resus thoracotomy
3. Cardiac surgeons at the MTC need to provide emergency assistance to stem massive thoracic haemorrhage
4. A rib fracture fixation service in Cardiff needs to be based in orthopaedics with back-up from thoracic surgery
5. The thoracic surgeons need to take ownership of complex thoracic trauma and this will require good communication and regular ward rounds in the MTC (probably best coincided with the days that thoracic outreach clinics are scheduled at the MTC).

(18.06.19)