Meeting Date	**30 May 2019**	**Agenda Item**	**2.3**
Report Title	**Update on Adult Thoracic Surgery Implementation Programme**		
Report Author	Joanne Abbott-Davies, Assistant Director of Strategy & Partnerships		
Report Sponsor	Siân Harrop-Griffiths, Director of Strategy		
Presented by	Siân Harrop-Griffiths, Director of Strategy		
Freedom of Information	Open		
Purpose of the Report	Swansea Bay University Health Board is responsible for leading the implementation of the new pattern of Adult Thoracic Surgery services across south east Wales, west Wales and south Powys, working with the 5 other Health Boards affected and the Welsh Health Specialised Services Committee (WHSSC) who are the commissioners for this service.		
Key Issues	This report outlines for the Health Board the background to these service changes, the governance which has been put in place to oversee this programme, the progress made to date and the further work planned to take this programme forward.		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐
Recommendations	Members are asked to: • **ENDORSE** the governance arrangements outlined in this report for the implementation of the new pattern of services for Adult Thoracic Surgery; • **NOTE** the progress made to date in planning the implementation of the Adult Thoracic Surgery Centre for south Wales, west Wales and south Powys; • **NOTE** the actions planned to take this work forward; • **AGREE** that a further report should be brought to the July meeting of the Health Board to update on progress.		

UPDATE ON ADULT THORACIC SURGERY IMPLEMENTATION PROGRAMME

1. INTRODUCTION

Swansea Bay University Health Board is responsible for leading the implementation of the new pattern of Adult Thoracic Surgery services across south east Wales, west Wales and south Powys, working with the 5 other Health Boards affected and the Welsh Health Specialised Services Committee (WHSSC) who are the commissioners for this service.

This report outlines for the Health Board the background to these service changes, the governance which has been put in place to oversee this programme, the progress made to date and the further work planned to take this programme forward.

2. BACKGROUND

In November 2018 the six affected Health Boards supported the recommendation for a single adult thoracic surgery centre based at Morriston Hospital, subject to the requirement for a workforce plan to provide thoracic surgical cover to the Major Trauma Centre at University Hospital of Wales in Cardiff. .

Implementing this new model of a single adult thoracic surgery centre at Morriston Hospital for south Wales, west Wales and south Powys to replace the current two centres at Morriston and University Hospital of Wales is likely to take at least 3 years. This is because in addition to changing service pathways, there will be a requirement for capital development at Morriston Hospital which needs to be agreed with all 6 Health Boards involved, and funded through the all Wales Capital Programme. The scale of the capital likely to be required means that a full five business case will be necessary.

3. WORKFORCE PLAN

As identified above, the caveat associated with the provision of thoracic surgery services at Morriston Hospital depended on the delivery of a medical workforce rota to support Morriston and UHW services by May 2019.

The Medical Directors of Swansea Bay and Cardiff and Vale UHBs have jointly developed a proposal, which was considered by WHSSC at its May meeting. Following discussion at this meeting, further more detailed work was requested by the Committee, as set out in the letters attached at Appendix A.

There will therefore be a further report to the WHSSC Joint Committee in June and all Health Boards in July 2019 on this issue.

4. GOVERNANCE AND RISK ISSUES

In January 2019 the WHSSC Joint Committee agreed the governance arrangements for the implementation of the recommendations, which included Swansea Bay UHB establishing the Implementation Project Board which would report via its Health Board through WHSSC to the Joint Committee. This is the first report to the Health Board on progress with the implementation of the new model of service for adult thoracic surgery for south Wales, west Wales and south Powys. The Executive lead

for this work is the Director of Strategy with support for the implementation being provided from the Strategic Planning Team.

The South Wales, West Wales and South Powys Adult Thoracic Surgery Implementation Board has been established, with its first meeting on 15th February 2019. The terms of reference are attached as **Appendix B**. Central to taking this work forward is agreeing the detailed service model and associated care pathways for patients across the south Wales, west Wales and south Powys area, including, most importantly, the extent to which services such as outpatients, pre-assessment and post-operative reviews and support are provided more locally for patients, rather than all out of the centralised unit planned for Morriston Hospital.

Once established, the new planned Adult Thoracic Surgery Centre at Morriston Hospital will be one of the largest in the UK. To help define the pattern of services which will be provided at the new Centre and those which will be provided at a more local level, a Clinical Summit was held on 15th March 2019 which had 43 attendees, including clinical representation from WHSSC and all 6 affected Health Boards. In addition, the clinical lead for the Major Trauma Network was also in attendance to ensure support arrangements between the Thoracic services and the Major Trauma Network could be discussed.

The report of the Summit is attached as **Appendix C**. As a result of the Clinical Summit the following actions were agreed and progress against each of these and further actions planned are detailed below:

Action Agreed	Update on Action
Site visits to be arranged / discussions held with Thoracic Centres across the UK to understand the centralised vs local provision of services & relationships with Major Trauma Centres	Videoconferences established with different UK sites on 10th and 17th May to discuss key issues – standard questions have been agreed with all HBs. Responses will be written up in report and presented to 2nd Clinical Summit on 24th May 2019
Establishment of Task & Finish Groups to: - Define the service model and clinical pathways for the new service - Focus on recruitment / skills development /rotation of staff / culture change across the 2 existing Thoracic centres - Define the services required for benign conditions (area of unmet need currently)	Draft terms of reference for each Task & Finish group have been developed based on the issues identified at the Clinical Summit on 15th March. At the next Clinical Summit on 24th May 2019 each of these Task and Finish Groups will have their inaugural meetings, building on the findings from the Thoracic Centres across the UK. All 6 Health Boards and WHSSC have nominated representatives for these Task & Finish Groups and chairs for each group are being established. Membership of the Implementation Board will be reviewed and reduced

Action Agreed	Update on Action
	following the establishment of the Task and Finish Groups.
Prepare a Strategic Outline Case outlining the case for change and demonstrating the need for capital monies associated with this	First draft of the Strategic Outline Case has been prepared which is being reviewed internally by Swansea Bay UHB and which will be considered by the Implementation Board at its next meeting on 24th May.
Refresh demand and capacity modelling once service model is agreed	This will be completed once the service model and associated pathways have been agreed.
Finalise agreement of cover requirements from Thoracic Surgery to Major Trauma Centre	The proposals relating to this are under discussion and WHSSC will be reporting back to the Joint Committee in June on progress with this.
Formally agree Clinical Lead role	This is under discussion between the Medical Director of SBUHB and the clinicians involved.
Develop and agree proposal for project management support	This has been discussed with WHSSC and confirmation of availability of funding is awaited. In the meantime the planning and support for this project is being provided by the Strategic Planning Department working closely with the Morriston Delivery Unit, WHSSC and other Health Boards.
Gather & analyse benchmarking information from English networks	Contacts at WHSSC are being utilised to gather any benchmarking information available.
Set up patient and carer engagement programme to ensure experiences influence future service model	Patient and Carer groups are not in existence across the area affected for people who have experienced thoracic surgery. Therefore it is proposed that the “In Your Shoes” methodology developed and used extensively by Swansea Bay UHB will be utilised to hold a series of focused conversations with patients and carers across the region to understand their experiences of the current services and how these could be improved going forward. A proposal to take this forward will be

Action Agreed	Update on Action
	discussed at the next Implementation Board on 24th May.
Implementation Plan to be developed for the new Unit and associated services across the south Wales, west Wales and south Powys areas	An initial plan has been developed to ensure the service model and actions outlined here are delivered in a timely manner. It has been agreed that the programme's implementation plan will be agreed by the Implementation Board by September 2019.

A further Clinical Summit was also held on 24th May to progress the development of the care pathways.

5. FINANCIAL IMPLICATIONS

The basis of this service change from a revenue point of view has been on delivery of current activity levels plus 20% at the Morriston Centre on a cost neutral basis. Should any additional costs be identified (such as additional workforce costs) these would be managed through the WHSSC prioritisation process for incorporation into affected Health Board's Integrated Medium Term Plans.

There will be a requirement for capital in order for the new Thoracic Surgery Centre at Morriston to be developed, and this is currently not included in the Welsh Government's capital programme, although clearly Welsh Government are aware of the requirement for this going forward. WHSSC will be invited to attend the Swansea Bay UHB capital review meeting with Welsh Government in summer 2019 to discuss this requirement. The intention in the meantime is to progress work on the Strategic Outline Case so that this is ready for submission when required.

6. RECOMMENDATION

Swansea Bay UHB is asked to

- **ENDORSE** the governance arrangements outlined in this report for the implementation of the new pattern of services for Adult Thoracic Surgery;
- **NOTE** the progress made to date in planning the implementation of the Adult Thoracic Surgery Centre for south Wales, west Wales and south Powys;
- **NOTE** the actions planned to take this work forward;
- **AGREE** that a further report should be brought to the July meeting of the Health Board to update on progress.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☒
	Digitally Enabled Health and Wellbeing	☒
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☒
	Digitally Enabled Care	☒
	Outstanding Research, Innovation, Education and Learning	☒
Health and Care Standards		
(please choose)	Staying Healthy	☐
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

The establishment of a single Adult Thoracic Surgery centre for south Wales, west Wales and south Powys should result in improved patient outcomes and quicker access to treatment. Using patient and carer experiences of current services to plan future services should ensure that these are taken into account in the new models of care.

Financial Implications

Revenue costs are planned to be cost neutral at this stage, based on current activity across the 2 units plus 20%, but any additional costs would be managed through the WHSSC prioritisation process and then into all 6 Health Boards' IMTPs. Capital costs will need to be agreed from the All Wales Capital programme.

Legal Implications (including equality and diversity assessment)

As part of the engagement and public consultation on this service change a number of issues were raised and assurances have been given that mitigations to address these will be included in the new model of services developed.

Staffing Implications

Establishing the new central unit for Adult Thoracic Surgery at Morriston Hospital will mean that staff currently working in UHW, Cardiff will need to transfer to the new service. It is recognised that this could be problematic to achieve and the establishment of the Workforce Task and Finish group outlined above is seen as critical to ensuring stability of services while the new model is being agreed and implemented, and enabling the appropriate transfer of staff into the new service when it goes live.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)

The new pattern of services planned will ensure the long-term sustainability of these services for the region. Integrating this specialist service with local respiratory and related services will be critical to its successful operation. Involving patients and carers

in helping define the new models of care will be important to ensure that their needs can be met effectively by the new pattern of services.	
Report History	None
Appendices	Appendix A – Terms of Reference for Implementation Board Appendix B – Report on Clinical Summit held on 15th March 2019

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

Your ref/eich cyf:
Our ref/ein cyf: VH.KS.DD
Date/dyddiad: 15th May 2019
Tel/ffôn: 01443 443443 ext. 8131
Fax/ffacs: 029 2080 7854
Email/ebost: Vivienne.harpwood3@wales.nhs.uk

The Chair and the Board Secretary:

Anuerin Bevan UHB
Cardiff & Vale UHB
Cwm Taf Morgannwg UHB
Hywel Dda UHB
Powys THB
Swansea Bay UHB

Dear Colleague

Re: Adult Thoracic Surgery for South Wales: Update

I am writing to provide an update on developments at yesterday's WHSSC Joint Committee meeting.

You will be aware that we had an agenda item to consider adult thoracic surgery for south Wales and accordingly received a paper on this subject. We had anticipated that the same paper would be forwarded to you for consideration at your health board May 2019 Board meeting with an endorsement from the Joint Committee.

In respect of the recommendation that a decision regarding the workforce arrangements that have been developed to provide thoracic surgical cover from Morriston Hospital, Swansea, for the MTC in UHW, Cardiff be deferred to July 2019, members decided, instead, to request Dr Sian Lewis (and the WHSS Team) to 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 raised in the paper and during the meeting.

In relation to the other recommendations set out in the paper, after due consideration, Members:

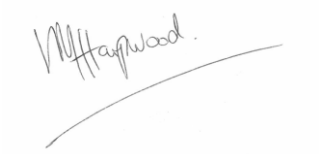
- **Noted and received assurance** that arrangements are in place to address the further issues raised by the affected health boards in November 2018;

- **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: "To support the recommendations going forward to the six affected health boards and the affected health boards being asked to confirm their unconditional approval for a single adult thoracic surgery centre for south Wales, and parts of mid Wales, based in Morriston Hospital, Swansea." was postponed.

Please circulate this letter to your directors for noting at your May 2019 Board meeting.

Yours sincerely



Professor Vivienne Harpwood
Chair

cc Andrew Goodall, Chief Executive, NHS Wales
Simon Dean, Deputy Chief Executive, NHS Wales

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

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The Chair and the Board Secretary:
Anuerin Bevan UHB
Cardiff & Vale UHB
Cwm Taf Morgannwg UHB
Hywel Dda UHB
Powys THB
Swansea Bay UHB

Dear All,

Further to my letter of the 15th of May I have been asked to provide further information regarding the work to be undertaken by the WHSS Team to develop the commissioning proposal for the consultant staffing model to be brought back to the Joint Committee for consideration at the end of June 2019. We have listed the actions identified in our meeting notes however it is important to note these have not yet been confirmed and are provided to give an indication to Boards on the scope of the work:

1. Detail regarding the anticipated demand for thoracic surgery in south Wales, this will include out-patient and surgical activity and allow for the planned 20% increase in activity.

2. Expert advice on the level of activity required to maintain consultant thoracic surgeons' skills.

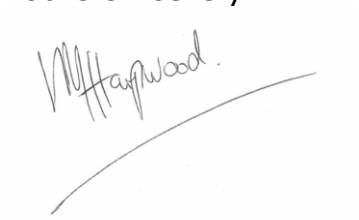
3. Development of indicative job plans for consultant thoracic surgeons to inform an assessment of the appropriate number of consultants.

4. Detailed costings for any proposed increase in consultant thoracic surgeons above the original WHSSC recommended level of six consultants.

5. Clarity on the role of trauma surgeons in the immediate management of emergency trauma patients and the requirement for input from thoracic surgeons (eg telephone advice or on site input)

6. Clarity on the interface of thoracic surgeons in managing trauma patients with other specialties (e.g. rib fixation with orthopaedic surgeons).

Yours sincerely



Professor Vivienne Harpwood
Chair

cc.

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Chair/Cadeirydd: *Professor Vivienne Harpwood*
Managing Director of Specialised and Tertiary Services Commissioning/Rheolwr Gyfarwyddwr Comisiynu Gwasanaethau Arbenigol a Thrydyddol: *Dr Sian Lewis*

Appendix A

SOUTH WALES THORACIC SURGERY IMPLEMENTATION BOARD
TERMS OF REFERENCE

1. PURPOSE

The purpose of the South Wales Thoracic Surgery Implementation Board Group is to plan the implementation of a Regional South Wales Thoracic Surgery Centre and associated services ensuring a safe effective quality service is established.

2. ROLES AND RESPONSIBILITIES

The South Wales Thoracic Surgery Implementation Board Group will:

- Lead on the development of commissioning discussions with the Welsh Specialised Services Committee and support the Swansea Bay University Health Board in delivering services.
- Lead on the implementation of a South Wales Thoracic Surgery Centre based at Morriston Hospital.
- Lead on the development of pathways from referral/emergency admission through to discharge and follow-up.
- Advise on the development of a South Wales Thoracic Surgery network of services.
- Lead on the development of business cases as required to meet the agreed requirements of the Thoracic Centre and associated services.
- Identify areas that address population needs, inequity of access, inequalities in health, local issues of clinical safety and quality.
- Overseeing the implementation of the service specification for thoracic surgery services provided for the population, which include key standards and outcomes measures.
- Working in a highly engaged way which ensures all stakeholder including, clinicians, patients and carers are involved in identifying issues, developing plans, including recommendations to change or remove elements of services or pathways.
- Review and ensure appropriate management structure to support the South Wales Thoracic Surgery Network.
- The South Wales Thoracic Surgery Implementation Board will establish sub groups or task and finish groups to carry out on its behalf specific aspects of work.
- Provide a link to the Major Trauma Network on relevant care pathways and services.
- Ensure clarity regarding patient flows through all aspects of thoracic care.

3. MEMBERSHIP

Membership shall consist of the following representatives:

- Director or Strategy, Swansea Bay UHB
- Unit Medical Director, Morriston, Swansea Bay UHB
- Unit Service Director, Morriston, Swansea Bay UHB
- Associate Service Director, Morriston, Swansea Bay UHB
- Head of SLR and Commissioning, Finance, Swansea Bay UHB
- Associate Director of Finance, Morriston, Swansea Bay UHB
- Unit Finance and Business Partner, Morriston, Swansea Bay UHB
- Senior Matron, Cardiac, Morriston, Swansea Bay UHB
- Specialist Nurse, Cardiothoracic, Cardiff & Vale UHB
- Clinical Director, Cardiothoracic Surgery, Morriston, Swansea Bay UHB
- Assistant Director of Strategy, Swansea Bay UHB
- Consultant Anaesthetist, Morriston, Swansea Bay UHB
- Head of Pharmacy, Acute Services, Swansea Bay UHB
- Theatres representative, Swansea Bay UHB
- WAST representative
- Cancer Network representative
- Head of Strategic Planning, Swansea UHB
- Medical Director, Cardiff & Vale UHB
- Directorate Manager, Cardiac Services, Cardiff & Vale UHB
- Head of Operations and Delivery, Cardiff & Vale UHB
- Clinical Lead, Thoracic Surgeons, Swansea Bay UHB and Cardiff & Vale UHBs
- Assistant Director of Finance, Cardiff & Vale UHB
- A clinical and managerial representative from each of the following health boards: Aneurin Bevan, Hywel Dda, Cwm Taf and Powys UHBs
- Managing Director, WHSSC
- Director of Planning, WHSSC
- Patient representatives, 1 from ABUHB and 1 from Hywel Dda HB
- Representative of Board of Community Health Councils
- Major Trauma Network Clinical Lead

4. GOVERNANCE ARRANGEMENTS

Reporting and accountability:

- The South Wales Thoracic Surgery Implementation Board shall be accountable to, and provide regular updates on progress to Swansea Bay University Health Board and then to other Health Boards via the WHSSC Joint Committee.

- The South Wales Thoracic Surgery Implementation Board to provide update reports to the ARCH Service Transformation Programme Board and Morriston Management Board.

- A project plan and risk log shall be drafted and maintained by the South Wales Thoracic Surgery Implementation Board.

- It is expected that the South Wales Thoracic Surgery Implementation Board shall meet monthly.

Quorum & Chair

- Director of Strategy, Swansea Bay University Health Board, shall chair the South Wales Thoracic Surgery Implementation Board.

- At least four Health Boards must be present, including at least two representatives from Swansea Bay University Health Board and one from Cardiff & Vale UHBs plus a representative from WHSSC.

Secretariat

The South Wales Thoracic Surgery Implementation Board will be supported by the Strategy Department, Swansea Bay University Health Board.

Actions/outcomes will be documented and sent out by the Strategy Department, Swansea Bay University Health Board. Planning and communication of dates and times for meetings will be coordinated by the Strategy Department, Swansea Bay University Health Board.

Review

These terms of reference will be reviewed 6 months after their sign off. Membership to reviewed following the establishment of T&F groups

Version 3 – JAD – 17.04.19
Agreed 24.04.19

Appendix B

South Wales Adult Thoracic Surgery Clinical Summit

Friday 15th March 2019

Conference Report

South Wales Adult Thoracic Surgery Clinical Summit

Waterton Centre, Bridgend CF31 3WT
Friday 15th March 2019

PROGRAMME

Time	Session	Speaker
9.00	***Registration & Refreshments***	
9.30	**Welcome and Introductions**	**Dr Richard Evans** Medical Director, ABMU Health Board
9.40	**Why a single thoracic centre? Commissioning Framework**	**Karen Preece** Director of Planning, WHSSC
10.10	**Feedback from visits to other thoracic surgical centres**	**Louise Jenvey** Matron, Cardiothoracics Services, ABMU Health Board
10.50	**What could a single centre look like?**	**Mr Pankaj Kumar** Clinical Director, Cardiothoracic Surgery, ABMU Health Board **Neil Miles** Associate Service Director, ABMU Health Board
11.10	***Coffee Break***	

Time	Session	Speaker
11.30	**Relationships with Major Trauma**	**Dr Richard Evans** Medical Director, ABMU Health Board **Dr Graham Shortland** Medical Director, Cardiff & Vale University Health Board
11.50	**Workshop session 1**	**Thoracic + Major Trauma interdependencies**
12.45	***Lunch***	
1.15	**Welcome back**	**Malgorzata Kornaszewska** Clinical Lead for Implementation of Thoracic Network
1.20	**Workshop session 2**	**Local vs centralised services for adult thoracic surgery**
	Refreshments ***Coffee and Tea will be available to take into workshop 3***	
2.20	**Workshop session 3**	**Managing benign conditions**
3.20	**Next steps & Close**	**Siân Harrop-Griffiths** Director of Strategy, ABMU Health Board
3.30	***Close***	

The slides from the Clinical Summit are included with this report for completeness.

Attendees

Alex Brown	Consultant Respiratory Physician	Cwm Taf
Alexandra Simmonds	Radiology Service Manager	ABMU
Cherri Douglas	Service Manager, Cardiothoracic	ABMU
Chris Moss	Head of Planning (Scheduled Care)	Cwm Taf
Chris White	COO	ABMU
Christopher Bowden	Cellular Pathology Service Manager	ABMU
David Hanks	Senior Planning & Service Development Manager	Aneurin Bevan UHB
David Martin	Consultant radiologist	ABMU
Diane Edwards	Theatre matron	ABMU
Dindi Gill	Clinical Lead, Trauma Network	NHS WC
Emrys Evans	Consultant chest physician	ABMU
Francois Lhote	Consultant Thoracic Surgeon	ABMU
Graham Shortland	Medical Director	Cardiff and Vale UHB
Hannah Rix	Assistant Service Group Manager, Surgery Service Group	ABMU
Heather Edwards	Business Planning Manager	ABMU
Ian Ketchell	Consultant and Director of CF Unit	C&V
Ira Goldsmith	Consultant thoracic surgeon	ABMU
Joanne Abbott-Davies	Assistant Director of Strategy and Partnerships	ABMU
Karen Evans	Acting Associate Director of Finance	ABMU
Karen James	Team Leader Critical Care	ABMU
Karen Preece	Director of Planning	WHSSC
Lee Davies	Operational Planning Director	Cardiff and Vale UHB
Louise Jenvey	Matron, Cardiothoracic Services	ABMU
Luke Archard	Planning Manager	WHSSC

Malgorzata Kornaszewska	Clinical Lead for Implementation of Thoracic Network	
Michael Gilbert	Consultant Anaesthetist	ABMU
Neil Miles	Associate Director, Surgery	ABMU
Nick Gidman	Directorate Manager	Cardiff and Vale UHB
Nicola Dickens	Sister	ABMU
Pankaj Kumar	Consultant Cardiothoracic Surgeon	ABMU
Paul Stuart Davies	Head of Nursing Surgery, Surgical Services Group	ABMU
Richard Evans	Medical Director	ABMU
Robin Ghosal	Respiratory consultant	Hywel Dda
Sameena Ahmed	Consultant Anaesthetist	ABMU
Sean Evans	Radiology	ABMU
Siân Harrop-Griffiths	Director of Strategy	ABMU
Sian Lewis	Managing Director	WHSSC
Sinan Eccles	Consultant, Respiratory Medicine	Cwm Taf
Stewart Dow	Theatre matron	ABMU
Stuart Hughes	Speciality Manager Recovery, Morriston	ABMU
Tim Havard	Cons. Surgery	Cwm Taf
Vasileios Valtzoglou	Consultant thoracic surgeon	Cardiff & Vale
Wyn Parry	Medical Director	Powys

With thanks to the speakers:

Dr Richard Evans, Karen Preece, Louise Jenvey, Mr Pankaj Kumar, Neil Miles, Dr Graham Shortland, Malgorzata Kornaszewska and Siân Harrop-Griffiths

And to the facilitators:

Patricia Jones, Amanda Davies, Hannah Rix and Cherri Douglas

And the organisers:

Michelle Crossland, Patricia Jones, Catrin Evans, Skye Banks and Joanne Abbott-Davies

QUESTIONS AND ANSWERS FOLLOWING PRESENTATIONS

Feedback from Visits to other Thoracic Surgical Centres - Louise Jenvey, Matron, Cardiothoracics Services, ABMU Health Board

Q If you were a patient which model would you like to be admitted to from the sites you visited?
A: It would be Nottingham. They have a very slick model.

Q. How long did patients spend in PreAssessment Clinics (PACs)?
A: Would aim for Nottingham model - PAC runs 5 days a week, just for thoracic patients. Patients are told to expect to be there all day depending on their needs. Patients are reviewed by nurses who go through everything with them. The nurse would triage the patient, decide if the patient needs to be seen by the Anaesthetist, physio or doctor. All staff worked together, and anaesthetists were happy with this process. Physios would hand out exercise worksheets to be done before admission.

Q: What about frailty of patients.
A: There was a frailty test as part of the PAC.

Q: Is this all set up for cancer patients, what happens to the non-cancer patients?
A: Surgical patients went to the ward, but other patients were admitted to medical wards and thoracic surgeons would have to visit those areas.

Q Not all patients would have seen an anaesthetist before admission, shouldn't all patients see an anaesthetist before then?
A: The majority of patients were seen via PAC by an anaesthetist.

Q: We have used this model from Nottingham which encompasses not only lung cancer but other conditions and is probably best model to use.
A: It is not just for cancer patients it is for all patients, their next available slots were given to any patient, it is so organised there is no waiting.

Q Regarding prehab services. There are a lot of patients that come in for surgery are not in the best condition.
A: There is a prehab service currently run in Morriston which is very effective but the Nottingham model is what we are aiming for.

Q: Recognise visits were predominately looking at thoracic surgical centres, but what happened with outreach services and nursing teams working within the outreach centres.
A; It was a large catchment area, a thoracic nurse visited all local hospitals if they were needed, did not discuss what happened in detail.

What could a single centre look like? – Mr Pankaj Kumar, Clinical Director, Cardiothoracic Surgery & Neil Miles, Associate Service Director, ABMU Health Board

Q: Recognise relatively early on in the process, but thinking about bricks and mortar at the start. You spoke of a combined single centre, potentially doing the same number of cases as the two larger centres in the UK which have the benefits of being in larger cities as opposed to smaller cities. What is the thinking for manpower and how will we recruit if we are to be the third largest biggest centre in UK.

A: There has already been some thinking about this. The time for upskilling staff should be now, creating a structure to attract people from UK/Globally. A process for potential transfer of workforce and skills from UHW to Morriston needs to be established, looking at how different staff within the team will be looking after thoracic patients and how we can attract staff going forward.

We need to recognise the challenges to mitigate the risks. We have faced significant challenges in recruiting to critical care at Morriston, but since the expansion of our Critical Care facilities this has made it easier to recruit with the right environment people want to work in. The implementation process and timeline gives us an opportunity to build up recruitment locally, upskill staff and develop leadership with the required wider workforce uplift to support this.

We have previous experience with successfully addressing recruitment problems, but we need to actively recruit, making the service attractive to people, and approaching this differently and with ambition.

Q This is an important and exciting time and we should not be squeezing the new service into limited space as the current discussions have identified that this new service will not fit into the current identified space. We don't want this centre ending up with restrictions and need to discuss what is needed for the centre.

A: We understand these concerns, and it's important to recognise that the potential location for the service was identified as a required part of the evidence submitted to the Independent Panel. It is important that going forward we identify key adjacencies and this afternoon's discussion about trying to define further what is needed to be provided locally or centrally will be key to defining what the infrastructure and buildings will need to be. We need to look at Louise Jenvey's slides and the Nottingham model as well as others to give us a wider prospective on how the service should operate. Until the service model is defined and we understand the exact requirement and adjacencies we do not know what the exact footprint of a building will need to be. The ideas to date about buildings are thoughts, preparatory work, but nothing is being ruled out. Today is to start the process of agreeing how services will run and we will then do the detailed work on the facilities required to deliver this. We are all signed up to be a world leading centre and have given a commitment in relation to that.

Q Slides show sets requirements for beds, what about preassessment clinics, Nottingham clinic is fantastic but this is limited in ABMU this is something which has to be well planned in its approach.
A: Agreed, but we need to agree where preassessment clinics should take place - in one or a number of places. If some things happen locally or in the centre, anaesthetist and surgery will be at central site but if site runs an MDT cannot see why cannot do preassessment clinics as well. Practically there are several models around the country with a number of pros and cons, need to evaluate all options and see what will work for us.

Q: Karen Preece presented that as part of the decision making for Morriston, that the site has space to hold a centre. Not sure what is the right model - do not think Nottingham is it, as it's a smaller centre. Readmission rates of 42% really high, we do not have those high rates in Wales, cannot afford those sort of rates that they have in large centres. We need additional capacity but Nottingham resection rate is not good. I do not think this is the right model, a separate build is the right way.
A: The options appraisal on possible sites on the Morriston site will take place once the service model has been agreed and therefore the service requirements for the Centre defined. This will have to go through a capital procedure process and be discussed and agreed. Nothing has been ruled out or which model will go with and all Health Boards will be part of these discussions.
The service model and how the service will run will defined what needs to be built. Once we are clear on how we are going to deliver services, we will design and build whatever meets these needs. ABMU Health Board wants to give assurance that we will go back to revisit the options appraisal in conjunction with partner Health Boards. We will deliver what is required once we have agreed what the configuration of services will be. The service model must come first.

Q: Have diagnostics been factored in to the proposals as well as pathology as this will have a big impact on our services.
A: All diagnostics have been included in the figures and discussions to support the centralisation of services. Will need to consider what will be done locally or centrally and where possible for things to be done closer to patients.

Q: How many operations must be performed to remain safe?
A: 150 major cases would need to be performed to remain safe.

Q On the slides there is no rehab area within the facilities
A: This is not a definite list of facilities required, this will be determined by the service model. We will need to define what prehab is delivered locally by therapies and what at the Centre. However provision of rehabilitation is an essential service requirement. Again we need to define the service model and design the facilities required from there.

Workshop Session 1
Thoracic and Major Trauma interdependencies

Table 1

- IT Infrastructure (enabler to communication)
    - Videoconferencing to facilitate at the bedside — virtual reviews
- Availability of consultant workforce - Outpatients / POA / Surgery
- Diagnostics and Therapies
- Consideration of available skill sets e.g. rib fractures, T+O
- Transport links between centres
- Repatriation pathways back to local services
- What does "local" mean? Geographical boundaries
- Discharge pathways need to be considered regionally
- Clarity of on-call arrangements/OOH cover/Junior Doctor Cover
- CNS Outreach
- Pathway Design — based on clinical condition – Morriston vs Local – preoperative assessment / MDTs / outpatient clinics / follow up clinics
- Mobile Team
- Team Job Planning
- Clinical Leadership
- Benchmarking with English network
- Capacity and demand modelling (+20%)

Table 2

- Not in/dependencies - Thoracic Supporting Trauma
- How close are we to having people in post to undertake procedures —trained
- Trauma centre to open April 2020
- Can train staff in UATS/Thoracotomy/in our theatre
- Depends on skill set currently
- What skill sets are in place currently to man the MTC rota
- What are the training requirements and timeframe
- Training element — not sure if can train with best skills
- Need to train for first line responders
- Will need to train a large number of people big ask within timescales
- Funding
- Monies given to English centres not in Wales.
- Can de-skill wider work of the Team
- How are we going to deal with major crisis
- How to service Trauma as a network with Major Trauma Units plus at Swansea and UHW (which should then meet the requirements)
- How do you concentrate CT/Thoracic in MTC

- Small number of patients will need immediate care
- 1st set of skills here and now
- 2nd set required
- Equip trauma surgeons to deal with high level injuries
- Who will gatekeep these patients i.e. Significant thoracic injury — Morriston/UHW
- Need to look at it as a network
- Ask trauma network who is going to triage these patients upfront.
- Not clear how MTC is going to triage/retrieve patients
- What is data for blunt and penetrative trauma
- Critical care for MTC is different
- Training key
- What level of thoracic cover required by commissioners e.g. on site/tel. advice/double rota
- Wider group of patients admitted across sites.
- Mechanism needed to review chest injury across entire network
- Formulating a pathway
- Review trauma/chest injury — mechanism review/advise
- Admission/next day
- Trauma MDT/Virtual MDT
- Management of rib fracture which does not need surgical input — what happens to those patients
- Rib fracture pathway — standardisation required
- Who does rib fixation — round country is variable — i.e. thoracic, general, trauma surgery and orthopaedics
- What do other trauma centres do i.e. England – should inform us/not start from scratch
- What will rotas look like
- Look at their databases — who performed intervention will inform what took place
- How can trauma surgeons and MTC at UHW support thoracic surgeons in Swansea
- How going to support staff, facilities, back up at Swansea — Thoracic surgery
- What support do the Trauma Surgeons need from Thoracic Surgery

Table 3

- Responsibility of reports and reporting process
- Radiology imaging — electronic availability being shared through the network
- Reports and images not currently linked — process needs to be slicker
- Availability to talk to radiologists between sites to discuss images
- How would consultants be expected to get to Cardiff — would they have police escort/ambulance?

- Backup system for major trauma between Swansea and Cardiff required
- Additional Team? SPR. Scrub, post-op care, skill mix. ?thoracic theatre, expertise is in Swansea
- Should these patients be transferred to Swansea? Difficult with multi trauma
- Could/should patients be triaged prior to transfer?
- Non brain injury patients should be in Swansea
- Clear pathways required for ambulance teams
- Timing is crucial
- Compelling priorities
- Having the availability of an appropriate on call network to ensure timely access to information and care
- Importance of digital access, on call person/team being able to access information prior to arrival at theatre
- Consideration of rotation between Cardiff and Morriston staff to understand theatres, teams to establish links
- Availability of theatre trays
- Need for education for Trauma teams, having the right skill set in theatre
- Cardiff cardiothoracic nurses/team will lose their skills — need for them to be maintained. How do we do this?

Table 4

- Trauma Centre from April 2020
- Needs to inform developments in Thoracics
- Utilising time of Thoracic Surgeons in UHW
- What can be introduced locally earlier?
- What is the thoracic surgeon going to be needed for in under 1 hour in MTC
- Urgency of non resus surgery?
- Can this capacity be used to support flow and local services
- Is there really a need for a thoracic surgeon on site 5 days/week or 24/7
- Will a thoracic anaesthetist be required in UHW
- There are other MTCs without Thoracics – what can we learn from them? How can we mitigate issues?
- Can we learn from the service model for Plastic Surgery
- Would resus surgeons reduce the requirement for dedicated thoracic trauma input?
- Will most patients only require Thoracics input the next day following stabilisation?
- What does MTC need from Thoracics – need to work well together – ABM surgeons on C&V rotas etc.
- The service needs to be mapped out, will it be a few times a year that someone is called out – or more frequent, may need to adapt as move forward
- Will have a local presence on site – could this sustain the trauma activity?
- Teamwork will be vital – culture change required

Workshop Session 2
Local vs centralised services for adult thoracic surgery

Table 1

- Communication with Health Boards needed about availability of rooms
- Infrastructure
- Chest drain clinic
- Therapies
- Psychological support
- Social Services
- GPs
- **Local**
    - Anything that can be delivered in a timely, safe, cost effective way should be local
    - Different levels of MDT
    - Outpatient clinics — no need for patients to go to hospital
    - Look at existing networks in England to see what they do.
- **Primary Care**
    - Access to the Welsh portal
    - Rehab timely information
- **Centralised**
    - Team working\ownership essential
- **Pre-assessment**
    - Option to include a visit to unit.
    - Patient to be informed that they will be discharged 4 days post op
    - Discharge planning i.e. bed downstairs if necessary.

Table 2

- Develop framework (Lung Cancer agreement on appropriate tests need consistent approach patient accepted)
- **PAC** — central or 2 site if anaesthetics/surgeons are happy to offer local service southeast
    - Run 5 days a week service
    - Nurse/anaesthetic/surgical rep/phlebotomist/thoracic CNS
    - Access to diagnostic results
    - Cross match bloods only done on site (one/two weeks before admission)
    - Pre-admission lounge — not beds chairs
    - Include all estate elements
    - Pre-op investigations need to standardise (remove variation) - Tick box list
    - Agree anaesthetist/surgeon
    - More staff/workforce
    - Specialist
    - Capacity

- **Local**
    - Pre surgery
    - Diagnostic — preplanned/booked
    - Prehab assessed/delivered locally
    - Hub/spoke
    - Standardised protocol
    - Already in place
    - Local training
    - Selection/delivery protocol
    - Standardise
    - Patient seen — rapid access clinic
    - Tests required/MDT referral
    - ERAS both local/central
    - Collaborative package of care/holistic care
    - Starts local and carries on patient journey
- **Post-Surgery**
    - Central
    - Helpline with Thoracic Nurse Specialist
    - First follow up central discharge from MDT back to local care
    - Need for acute pain service — post surgery
- **Local**
    - Rehab/OCC
    - Therapy/ Macmillan support
    - Providing surgeon attending local hospital (Prince Phillip)
    - Potential movement of rapid access clinic - Further west wales — need scope local clinics
    - What are patient preferences?
    - Repatriation

Table 3

- Prehab for all patients from 1st clinic (chest physicians)
- All diagnostic procedures organised locally
- Morriston — pre assessment
- Surgical clinic — local/depending on MDTs needs
- Prehab assessment — evaluation of social services and pathways (local hospital? other?)
- Follow up standardised
- Adapt workforce to follow up
- Respiratory Consultant and nurse input on Morriston ward (More ill patients)
- How to quantify extra work in Morriston. Respiratory/Radiology/Pathology/CNS
- Transfer of Radiology images should be sleeker and PET systematic fused pictures transfer
- Family accommodation and patient accommodation (day of surgery admission)
- Harmonised Bronchology work
- Bronchoscopy on call rota
- First post op clinic locally
- Outreach team forum Llandough

Table 4

- **Local**
  - MDTs
  - Outpatients with surgeon
  - Prehab
  - What is post op pathway?
  - Rehab
  - Education / training
  - Development of skills
- **Outreach**
  - Prehab / rehab
  - Combined clinics
  - Transport
  - CNS support
- **Central**
  - Surgery
  - One stop Preoperative Assessment (criteria led)
  - Expansion of surgeon workforce
  - Who is repatriated?
  - SPECIALIST INPUT ONLY
- PATIENT ENGAGEMENT
- Admin / booking structure
- COORDINATION
- Patient information – leaflets / DVDs / literacy
- Virtual /cross centre opportunities for MDT / Outpatients clinics/ preoperative assessment
- 5 MDTs, one stop shop surgeon / physician : C&V / Cwm Taf / Hywel Dda / Gwent / Swansea Bay
- What do we mean by “local”
- How do we manage patient expectations
- Patient anxieties
- Consistent discharge criteria
- Education / training
- Right place, right time
- Patient flow procedures
- Further benchmarking required
- Minimisation of travel for patients
- Organisation of preoperative assessment
- Regional pathway design
- Liverpool outreach to MDT

Workshop Session 3

Table 1

- Consistency of indications for referral — common referral review
- High cancellation rates for benign patients - ? dedicated lists — in theatre/dedicated theatre
- Is there a role for a benign conditions MDT? — post op recovery/ongoing support.
- Co-ordinator role should include benign conditions.
- Ward — post op patients only
- Dedicated recovery area for thoracic patients proximity
- Early repatriation protocols for these patients — unlikely to go home at day 4
- Allows a "nicer" case mix
- Central point of referral — electronic — build onto co-ordinator role
- Pleural biopsies referred for VATS — option for delivery via medical intervention instead?
- Standardisation — pathways pre and post op/theatre list/training
- Consistency
- Minimal variation
- *Co-ordinator Role*

Table 2

- Lung cancer swamps all work and drives the work — Benign not such a focus
- Health Board – ABMU - needs to take into consideration benign cases - primary focus cancer/ benign (not focused on/no rules/regulations lung) emphysema/COPD/lung volume reduction work - more intervention - endobronchial
- Develop links with Consultant chest physicians across South wales — Form MDT/rationalise treatment appropriately.
- Anticipated work 50 cases annually.
- Needs to be s 50/50 balance - Cancer/benign work
- ILD - not cover Il-D MDT - need to provide this to lung biopsy service - anticipated work 50 cases annually.
- Pneumothorax - anticipated work 100 cases annually
- Most will be emergency transfers
- Pleural biopsy - anticipated work - 50 cases annually
- Empyema - anticipated work - 100 cases annually - most will be emergency transfer.
- Mediastinum - Thymectomy - need form group neurologist/or MDT - develop pathway. This will need to evolve.
- Diaphragm surgery - anticipated 25 cases per year
- Mediastinoscopy - anticipated 25 cases per year

- Chest Wall
- Pectus repair — anticipated cases 50 per year.
- Thoracic inlet — need to form links vascular surgeon
- Chest wall reconstruction — sarcoma/chest wall tumours
- Sympathectomise — C&V provide ABMU would like to provide — 10 cases per year.
- Metastetectomies — colorectal/GU/Breast/Skin/Sarcoma. Anticipated 100 cases per year.
- Rib Fixation — like to do as thoracic surgery
- How we manage it
    - Organise MDT groups
    - Set protocol with patient pathways/management plans
    - 2 theatres per day and emergency list. Set out 3 dedicated theatres. A hybrid theatre.
    - Sufficient theatre — interventional space. Cancer works drives it — not benign. One theatre devoted to benign work. Training of staff — time to train. Plan ahead for trainees. Three theatres and one flexible space (?Hybrid)
    - Data on benign cases to compare from other centres.

Table 3

- Availability of Surgeon
- Protocol in situ - timely access
- Standard pathways - LVR, lung biopsies, VATS
- Capacity on Units
- MDTs - Pathologists in ILDT/MDTs
- Pathology increase in workload - speciality/expertise in reporting
- Differences in rates between Cancer and Benign between UHW/Morriston and reasons as to why.
- Myasthenia Gravis patients - need to provide. Surgery in Wales - at the moment they go to Oxford.
- Dining Room and Rehab Room on Ward - Earlier Discharge
- Culture - patients should be encouraged to wear their own clothes not PJs - told in pre assessment to bring in clothes and promote independence.
- Design of the Ward needs to promote independence/length of stay
- Recovery

Table 4

- Use of beds – cannot maintain current model – preoperative patients
- Rib fractures management – many don’t need surgical input – who should manage? – need medical consensus and pathway – Trauma Network with support from Thoracics
- Triaging trauma – chest injury to go straight to Morriston?

- Some hospitals have rib fixations only done by T&O, need to standardise treatment
- Major trauma thoracic ops very very very rare
- Listing equal measures of benign and cancer over 2 theatres, 5 days a week
- Aiming for 50:50 split, currently 70:30 so unmet need
- What is the unmet need?
    - Chest wall conditions
    - Lung diseases & conditions
        - Emphysema
        - Pneumothorax
        - Infective Pleural
- Where are these cases being treated now?
- Inpatient transfer close relationship needed with chest physicians
- These patients sit in hospital wards or don't come in
- No capacity – cancer has priority and we struggle to meet this need

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