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.

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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.
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.

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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
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.

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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
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

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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.

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15.	Consultant Thoracic Surgeon 1				We believe that it's unsafe and against current guidelines (Major Trauma Centre specification, GIRFT report) and recommendations to provide cover from a 42 miles distance.	Our external advice (see separate appendix) says that GIRFT is opinion rather than 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.

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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.

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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 ?+**

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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	Background	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.

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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.

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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.

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,

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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

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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

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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

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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.

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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.

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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

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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	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.

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					to attend to and deal with major thoracic injuries in a completely 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

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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.
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.

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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.

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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.

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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.

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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.
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

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64.	Health Board CEO 1	2	39	Background	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
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, 13-14 7		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.

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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

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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

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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.

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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
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.

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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.

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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	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.

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					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 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

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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.

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88.	Medical Director 3	6	23	MDTs	Anticipate no change to weekly surgical clinic at RGH	Point noted.
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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