Thoracic Surgery Consultant Work-force Model Expert Advice.

Teleconference 18.06.19

Attending:

Chris Moran, NHS England National Clinical Director

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

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

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

Sian Lewis, Managing Director, WHSSC

Karen Preece, Director of Planning, WHSSC

Background:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary:

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

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

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