THYROID SURGERY AND CANCER

Notes of a Meeting that take place on Friday 2nd March 2012

at the Royal Society of Medicine, London.

Present:

[Co-Chair] Mr. Greg Sadler, Endocrine and General surgeon, representing Prof John Macfie, President, ASGBI (Association of Surgeons of GB and Ireland).

[Co-Chair] Prof John Watkinson, President, BAETS

Ruth Bridgeman, Programme Director, National Cancer Peer Review

Dr Mike Burrows, CEO, NHS GM, and Chair Greater Manchester and Cheshire Cancer Network

Professor Nirmal Kumar, Asst. Secretary, ENT UK - Representing ENT UK executive Mr. Alan Johnson, ex-President, and the President, Prof. Valerie Lund, CBE

Mr. Sean Loughran, H&N / Lead Thyroid Surgeon representing the network's Head & Neck Site Specific Group, GMCCN

Toni Mathie, Director, Greater Manchester and Cheshire Cancer Network

Stephen Parsons, Director of the National Cancer Action Team

Dr Beng Yap, Chair of the Thyroid MDT, GMCCN

1. Introduction and Purpose of the Meeting

Introductions were made and it was acknowledged that Dr Mike Burrrow's letter had created the purpose for the meeting. Individuals then explained what they hoped would come out of the meeting including:

- To get an understanding of what minimum standard commissioners need to commission.
- To obtain guidance on the appropriate numbers of procedures for safe high quality surgery
- From a peer review perspective to get consistency across the country and to understand what would be considered sufficient numbers of procedures that need to be undertaken so as to ensure safety.
- To ensure that the right people have the right discussions at an MDT.
- To ensure good quality surgery especially as there is a move nationally away from giving radioactive iodine treatment.

2. Current Position in the Greater Manchester & Cheshire Cancer Network (GMCCN)

Progress in GMCCN since the Dr Burrows letter **dated 24th October 2011** was summarized as follows:

Action has been taken by 10 /12 Trusts i.e. those that carry out Thyroid surgery, and the latest position is:

- Low volume surgeons have ceased to carry out thyroid surgery.
- Trusts have rationalised the numbers of surgeons undertaking non malignant thyroid surgery, and identified and named **designated Thyroid surgeons**.
- Surgeons undertake **lateral neck dissections** only at Central Manchester (CMFT); Pennine; University Hospital South Manchester (UHSM). These are all **designated sites** for specialist Head

and Neck surgery. Tameside – A designated surgeon is carrying out basic neck dissections. He refers complex cases to Central Manchester a designated centre.

- Designated surgeons are now core / associate members of the Thyroid MDT.
- Consultants are attending and are referring all patients through to the thyroid MDT at Christie. Some of the consultants are saying that they will aim for 67% attendance as per Peer Review requirement.
    - **Issue**: Core members are not staying for the whole MDT.
    - **Issue**: Clinicians not having the time to attend two MDTs per week i.e. the Head and Neck MDT and the Thyroid MDT.
    - **It was confirmed that** – the peer review expectation is that:
        - Any surgical member of an MDT should be a core member.
        - Not acceptable to present their own patient at the MDT and then leave. It is essential that surgeons share their expertise and provide an opinion on all cases.
        - Attendance via a video link is acceptable.
        - The Specialist MDT should service a population of more than 1million
- **Numbers of Thyroid/Parathyroid procedures p.a**. (NHS, private, malignant & benign):
    - Bolton has 2 surgeons - one surgeon doing 50 procedures and one doing 16;
    - CMFT – 3 surgeons all doing > 30 procedures each
    - East Cheshire – 1 Surgeon doing 20 procedures ***
    - Central Cheshire – 1 Surgeon doing 20-30 procedures***
    - Pennine – 2 surgeons – both doing >30 procedures
    - Salford – 3 surgeons – All doing >20 procedures.
    - Stockport – 1 surgeon >30 procedures ***
    - Tameside – 1 surgeon > 30 procedures ***
    - UHSM – 1 surgeon > 30 procedures ***
    - Wigan - 2 surgeons – both doing > 30 procedures, and one of these surgeons does lateral neck dissections only at UHSM

    *** **Issue** – In some of the hospitals listed above where it looks as though there are single handed surgeons operating, the CEOs having received the 24th October letter may have asked any surgeon doing less than 30 procedures to stop. This will need to be revisited, as there may have been a valid reason for the lower numbers e.g. a new surgeon just starting etc.

3. Setting a Standard

3.1 Number of thyroid procedures

- Benign thyroid surgery cannot be separated from malignant surgery – as thyroid cancers are often diagnosed after initial surgery. It is a disease linked to hormonal changes, prevalent in women and is rising in the UK.
- Most DGHs will be doing around 50 procedures p.a., and will need two surgeons doing this work. [Concerns were raised about single handed consultants as they would have no cover when that surgeon goes on annual leave etc.]
- Originally ENT UK recommended doing 20-25 thyroidectomy procedures per surgeon p.a. along with: Audit; Appropriate training; Working in a team; MDT attendance; Member of an umbrella organisation e.g. ASGBI, BAETS, BAHNO, ENT UK, etc
- Current thinking is that for thyroid surgery – **20 thyroidectomies per surgeon p.a. would be considered safe.** [**Post meeting note**: BAETS is about to suggest 20 Endocrine procedures a year which does not distinguish between benign and malignant thyroid or other procedures such as parathyroid or Adrenal.]
- Two surgeons in a DGH doing 20 procedures each (i.e. at least 40 procedures per Hospital) would ensure that theatre teams would have sufficient procedures to develop and maintain their skills. To reduce mortality these patients also need to be looked after on an appropriate ward so staff are skilled in looking after airways.
- It was acknowledge at the meeting that National Peer Review quality measures specify a broad set of factors e.g. network agreed audit, membership, minimum attendance at meetings [which if met could be considered as leading to accreditation].

It was agreed that surgeons doing a **minimum of 20 thyroidectomy procedures p.a.** would be considered safe.
Rationale - A team of two surgeons in a DGH each doing 20 thyroidectomies – a minimum total of 40 per hospital – would mean that there would be approximately 1 thyroidectomy procedure carried out each week. This would assure surgeon's skills are maintained and also ensure that theatre teams would have sufficient procedures to develop and maintain their skills.
NB. When looking at numbers of procedures it is best to use three years data rather than one year, and take factors into consideration such as if a new consultant starts part way through the year will not have built up their numbers etc.

- **Issue - Inappropriate surgery** was raised – but it was acknowledged that although it is not possible to draw up guidelines for inappropriate surgery, this does need to be policed through the MDT [a figure of 5-10% is the norm].

- **Issue - Inequality of access to a good cytology service** was raised, which means that many patients have to have a two stage procedure. This needs to be addressed locally.

3.2 How can surgeons carrying out thyroid procedures demonstrate that their skills are being maintained?

Thyroid surgeons need to:
- Demonstrate that they are appropriately trained
- Be members of an appropriate national organisation – ASGBI, BAETS, BAHNO, ENT UK
- Be doing a minimum of 20 thyroid procedures per year – in order to maintain expertise and ensure best outcomes.
- Attend MDT meetings etc

Lymph Node Dissections

- Lymph node dissections should only be carried out by designated members of the MDT at the centre, but diagnosis can be done locally.
- High Risk patients should have lymph node dissections only operated on in designated centres – in line with the **national cancer Quality Measures relating to lymph node dissections.** All males and women over 40 are considered high risk and should only be operated on at the centre.

3.3 Who should seek assurance that thyroid surgeons skills are being maintained?

- **It was recommended** that the MDT / Network lead for thyroid cancers should seek assurance and ask surgeons to demonstrate that their skills are being maintained.

- **It was agreed that** surgeons in DGHs can do thyroid surgery, and thyroid cancer procedures as agreed by the MDT – but NOT lymph node dissections.

3.4 How can we ensure consistency in relation to this matter across all cancer networks?

- It was agreed that the minimum standard of 20 procedures per consultant per year would be taken beyond The Greater Manchester and Cheshire Cancer Network.

4. Next Steps

4.1 Toni Mathie to draft notes from the meeting and circulate for comment

4.2 Once notes are finalized, Stephan Parson, Director, NCAT will write a letter to all organisations ASGBI, BAETS and ENT UK covering areas that had been agreed.

4.3 ASGBI, BAETS and ENT UK – to take the letter to respective councils for endorsement and to notify all members.

4.4 This will also be used as the standard for thyroid surgery by the National Peer Review Team, and so will ensure consistency across the country.