

**Proposed congenital heart disease standards and service specifications:  
a consultation - 15 September 2014 to 8 December 2014**

**Consultation Questions**

**AIMS OF THE NEW CHD REVIEW**

**1a: Will the draft standards and service specifications meet these aims?**

- Strongly agree
- Agree
- Neither agree nor disagree
- Disagree
- Don't know

**1b: Please explain your answer**

The current system has suffered from planning blight, competition and in some cases enmity, it is not clear how this review will overcome these problems. Whilst individual team members (particularly surgeons) are discussed, that good results are delivered by competent and effective teams does not appear to be sufficiently emphasised. Networks will need to become effective teams and have leaders (not necessarily surgeons) who can engage all members in developing an outstanding regional (in its broadest sense) service. There are many fine words in this document but no obvious pathway to deliver change, there will be much resistance and leadership will be key. It difficult to understand how the costs of re-organisation will be absorbed without impacting on the revenue available for patient care.

**MODEL OF CARE**

**2: What do you think of the model of care that we are proposing?**

This sounds good in theory, but will be difficult to deliver in practise. Services are currently provided by a variety of different models, in different areas of the country. Re-organisation will be time-consuming and costly. It will be disruptive to many highly trained and valuable clinicians and support staff lives and they may prefer to change or limit the scope of their practise rather than moving cities and disrupting the lives of their families. Unhappy employees are non-productive and will not deliver an excellent service.

**3: What do you think about our proposals for level 2 Specialist Cardiology Centres?**

What are the attractions of a consultant post in a level 2 cardiology centre ? These posts given the paucity of trained individuals may be difficult to fill.

**NETWORKS** (Section A)

**4: What do you think of our proposals for the development of networks?**

This is a sensible idea, and should be seen as a way of formalising referral channels that already exist along with building relationships. Cardiology for CHD and GUCH surgery are highly specialized areas in which clinicians tend to know each other.

**STAFFING AND SKILLS** (Section B)

**5: What do you think of our proposals for staffing CHD services?**

Excellent aspirations, but probably difficult to implement in practise. Some surgeons and cardiologists have mixed practises, e.g. Adult GUCH/Paediatric CHD or GUCH/General Adult Cardiac Surgical Practise. Many of the skills are over-lapping and equally nursing expertise is similar. Super-specialisation to this high level over all staff groups may be difficult to achieve and it's not necessarily always desirable. A broader experience of different areas of cardiac surgery and cardiology can be beneficial.

**6: What do you think of our proposal that surgeons work in teams of at least four, each of whom undertakes at least 125 operations per year? Please explain your answer.**

Support, it is important that the team sees sufficient patients a year and this would produce a surgical throughput of 500 per year, this would enable skills to be developed and maintained in anaesthesia and critical care. Work life balance must be recognised to avoid burn out and produce attractive jobs for high quality clinicians.

**7: What do you think about our proposed approach to sub-specialisation?**

Good in theory, but not always practical. Any patient wants to be referred to the cardiac surgeon who has the best results on the 98<sup>th</sup> centile, but any one individual can only operate on a finite number of cases. Instead of being too prescriptive must emphasise the professionalism of individual doctors, encouraging people to ask for help with surgery beyond their areas of expertise and experience. Surgeons should be encouraged to operate together. Over time, the culture in cardiac surgery will change and there will be more co-operation within teams and between hospitals. The most complex CHD cardiology interventions and CHD operations could be limited to a few major centres.

**INTERDEPENDENCIES (Section D)**

**8: What do you think of the proposed standards for service interdependencies and co-location?**

Good in theory, but numerous competing factors . In the absence of a major injection of cash to redevelop the whole service each unit will need to make the best of what it has whilst recognising the need to provide seamless patient care.

**INTRODUCTION TO THE PROPOSED SERVICE SPECIFICATIONS (Part 3)**

**9: What do you think of the proposed service specifications?**

Training, education, organisation, governance, audit and research etc. will be facilitated in larger centres with a bigger case load.

**DELIVERING THE STANDARDS WITHIN EXISTING RESOURCES (Part 4)**

**10: To ensure that we work within the available resources, difficult decisions may need to be made. What parts of our proposals matter most to you?**

## ***New Congenital Heart Disease Review***

Networks, teams, build relationships. End planning blight and competition based on fear of losing a service. In short get on and make decisions and stick with them then let clinicians get on and make them work.

### **MAKING IT HAPPEN (Part 5)**

**11: Do you have any comments on the range of approaches proposed to ensure that the standards are being met by every hospital providing CHD care?**

.No

### **ANY OTHER THOUGHTS**

**12: Is there anything else that you want to tell us or to ask us to consider? If your comments relate to a particular standard or section please specify which you are referring to.**

The aspirations of this report may be difficult to achieve.

Clinical leadership will be fundamental