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Cardiothoracic transplantation: An executive director view

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Disclosure

- Appointed to a one month locum as a transplant registrar starting May 1993!
- Trust Chief Executive is a transplant nephrologist
- Clinical group Chief Executive is a cardiologist at Harefield
- Our focus is where we can add most value, in advanced cardiorespiratory disease

Transplantation is part of our DNA…..

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An executive perspective…..

- The trust executive are aware of the changing landscape for lung transplantation in particular
- In recent history, practice has been dominated by the large CF practice in the trust
- Recent therapeutic success has driven a refocus on a different (more challenging?) cohort

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An executive perspective…..

- One of the 6 nationally commissioned PH centres
- Extensive COPD practice, expanding LVRS service

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An executive perspective…..

- The Brompton ILD service saw around 1500 new patients/year and followed around 8000
- This has increased by 30% post-GSTT merger
- Monthly trust-wide MDT with the transplant team
- Collaborative research to utilise a digital monitoring platform

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An executive perspective…..

- Transplantation is, and will remain, a jewel in the crown- if utilisation was at 2017/18 levels would we be having this discussion?
- There is a broad acceptance that it will be a cost pressure to the trust- is this correct/should it be the case?
- Are we too willing to prioritise 'elective recovery' over delivery of transplantation? (lack of available theatres appears to be an important factor)

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What does the trust executive need?

- To understand the 'ask'- a contemporary service specification which sets out the 'what' and gives rise to the 'how'?
- Engagement at trust board/exec level- this conversation needs greater visibility (OUG recommendations 5/6/7)
- We need to understand our contribution both to delivery of transplantation, but also organ donation
- Understand the details of the blocks to delivery nationally and locally

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What does the trust executive need?

- Some consistency of approach/guidance to e.g. workforce planning- accepting that each centre will have individual workforce demographics which drive necessity
- Workforce model needs to support resilience- (recommendation 5/6 OUG report)
- Perhaps exploration of new models of job planning- including transplant 'specialists'? The funding stream needs to reflect this

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What metrics do we need?

- Context is all important- easy to set hares running at board level…….
- Consistent high quality data- we need to know what we need to know
- Transparency of the zoning process
- Collaborative approach to CUSUM monitoring

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What metrics do we need?

- We shouldn't wait for NHSBT to tell us what good looks like!
- Comparative data are helpful- as long as meaningfully comparative
- Utilisation of high quality donors/decline rate is important (particularly as appears to be so low)
- ? Waiting list mortality a constructive metric
- Likewise time from listing to transplantation

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Conclusions

- Cardiothoracic transplantation likely to continue to be viewed as an important part of trust identity
- Likely continued acceptance of challenging to deliver without being a cost pressure
- The above is an easier narrative if 'performing' well (utilisation, outcomes)
- A collaborative rather than adversarial approach will be of increasing importance, hence today is welcomed but needs to be part of an ongoing conversation which perhaps should involve a broader executive presence/contribution