

SOUTH WESTERN REGIONAL HEALTH AUTHORITYSTRATEGIC PLANNING WORKING PARTY - 14th FEBRUARY 1983REPORTS ON SERVICES FOR THE DEVELOPMENT  
OF OPEN CARDIAC SURGERY AT THE BRISTOL ROYAL INFIRMARY1. INTRODUCTION

1.1 At its meeting on 8th March, 1982 the Regional Health Authority received a detailed recommendation from the Strategic Planning Working Party relating to the open cardiac surgery Working Party report chaired by Dr. Gordon Mather during 1981. The resolution of the Regional Health Authority was as follows:

- the merits of the case of expansion of the open cardiac surgery service in the South Western Region to 600 cases per year be accepted in principle.
- in view of the anticipated nil growth in revenue no commitments should be made to implementing the recommendations of the report at present.
- steps should be taken to ensure that should revenue become available the Authority was in a position readily to develop this service by establishing the capital, staffing and equipment consequences of the proposed development.
- further consideration be given to looking at a range of investment by which this service could be developed, including the possibility of better utilisation of present facilities. Once a profile of costs for different levels of open heart surgery operations had been prepared further consultation would take place with District Health Authorities.

1.2 As a consequence of that resolution a project team was set up to look at the feasibility of expanding the workload at the Bristol Royal Infirmary to different levels of caseload and to ensure that the most efficient use was being made of existing resources. A copy of the project team's first report is enclosed with this paper which now goes on to deal with the consequences of that report if it is accepted by the Strategic Planning Working Party.

2. EFFICIENCY OF PRESENT SERVICE AND EXPANSION BY 100 CASES

2.1 Strategic Planning Working Party members will be able to see from the content of the report itself that an expansion by 100 cases can be achieved and in some aspects this does not require an increase in staffing. For example, the consultant surgeon workload could be increased by the added clinical throughput without the need for additional consultant staff. In most other respects some modification either in staffing or in accommodation is required though in terms of building alteration this is a very modest requirement compared with those anticipated by the original open cardiac surgery Working Party.