**Note of meeting of Board CHD sub group - 29 July 2013**

The group discussed progress to date including the recent Board paper and outline timetable, and the discussion on 18 July.

In discussion the following points were made:

- in response to the Secretary of State's request for an update by the end of July, the Chair would write to Mr Hunt, with a short explanatory letter, enclosing the Board paper
- an initial series of meetings with stakeholders was underway, including a meeting with local charities and patient groups, scheduled for 7 August
- NHS England would need to be able to reconcile the work of the new CHD review with the "Call to Action" - and explain clearly how the two were related
- the process for the new CHD review would establish a precedent for similar exercises in future dealing with other specialties and should, as far as possible, use the specialised commissioning approach (clinical reference groups to advise on standards, development of networks etc).
- we must avoid well-intentioned but misguided pragmatism, ie the path of least resistance, or simply developing a solution to accommodate every existing provider. NHS England must determine the characteristics of the best possible service and commission with that in mind
- the number of units, and the link between volume of activity and patient outcomes, were recurrent themes in early discussions. IRP had criticised the way in which evidence regarding volume and outcomes had been presented in the previous review. So – if the new review relied on numbers of cases per surgeon/centre, it would need to differentiate clearly between evidence and judgement
- irrespective of any evidenced link between volume and outcome, there were intuitive grounds for having four surgeons in each unit, to ensure sustainability and to "future proof" the service. These included mutual support, better on-call arrangements, opportunities for training etc. Having enough surgeons meant removing some of the stress of what was intrinsically a very stressful job
- similarly, the intuitive arguments for larger units, with greater concentration of expertise, were that public expectations were rising, pressures on surgical teams was greater, babies were operated on earlier and operations were increasingly complex. These were potential reasons for performing some of the most difficult and complex operations in a very limited number of centres
- it will be important to think radically about what is best for patients in the long term, which requires a focus on principles and standards, and how best to future-proof the service – for example anticipating changes in technology and clinical practice. This requires a broader approach than simply reviewing the merits of the current providers – how, for example, to best align leading edge research and current practice?
- given the need to consider adults' services alongside children's, the questions about the precise meaning of "co-location", and the need to consider the latest data and best projections, NHS England was not required to work towards a set number of units (eg reducing from 10 to 7). It may be that the conclusion of the review will be to prescribe a

number of units, which could be the same or fewer, but this was not the starting point of the review

- some stakeholders had raised safety concerns and there were undoubtedly risks during transition – this was being discussed with NHS England's patient safety domain lead and we would agree a consistent process to be followed. CQC had legal responsibility for essential levels of safety & quality, and NHS England could address issues locally through its regional medical directors working with CQC (eg in Quality Surveillance Groups), with potential escalation to the Chief Inspector of Hospitals
- as the sole national commissioner NHS England wanted a single national service to a single set of national standards, consistently applied. This may require some sharing of accountability, potentially though the way that contracts are let and managed (it was a matter of concern that relationships between centres appeared to have broken down).
- whatever the outcome of this review it was clear that there were practical issues to overcome, for example in the relationships between centres to help ensure an appropriate degree of co-operation and collaboration. NHS England would also need to consider how to support those affected by change – for example patients and families who might potentially need to use different services, and clinicians and staff whose units might be affected
- summing up, the Chair reiterated the importance of openness, transparency, clinical leadership and service user engagement in the way NHS England conducted its business. The success of this new review would depend in part on early clarity about the fixed points around which the service must be built, the use of formal standards and networks, and consideration of the sustainability and "future proofing" of the service, including links to research. This in turn would require careful thought as to how to rebuild damaged relationships and the potential for some sharing of accountability in a national service of the future.
- NHS England would continue engagement and discussion with a view to developing an initial proposition for discussion in the autumn.