Note of meeting with national clinical organisations, 16 July 2013

John Holden outlined the board paper due to be considered on 18 July.

The main points made during the meeting were as follows:

- there was a general welcome for the NHS England board paper on CHD services and the principles and approach described, but concern that no matter how transparent the process, there would inevitably come a point where difficult decisions had to be made – how would disagreement be managed?
- decisions would always rely on judgement as well as evidence – for example to describe the optimal approach – and the new review must be honest about use of expert opinion and how it was presented.
- the new review should be seen in the broader NHS context – part of a bigger debate in public about the future of NHS services, and not simply a niche argument about local "closures" which inevitably divided opinion on geographical lines
- some issues which had been set out in the draft service standards needed to be further clarified – for example what exactly did "co-location" mean? This was clearly important but some felt that it had been "fudged" in the past. Similarly some aspects of the model of care needed to be better understood – eg the logic for and precise role of cardiology centres
- important relationships (for example between surgical centres, and between their respective clinicians), which were good at the start of the last review, had been damaged. Whilst it was right that the new review should proceed at pace (because services were currently vulnerable) there was an equal risk that if the process was too hurried there would be no opportunity to rebuild these relationships. There may be a need for NHS England to provide/arrange some "diplomacy"
- the other side of this argument (proceeding at pace) was a general concern that a lengthy review would run up against the general election timetable and there would be a failure of political will to support agreed change – this was precisely why many clinicians were now sceptical/wary of engaging again
- cardiac surgery, although a dramatic and very important part of the patient pathway, was potentially only a small component of the care a patient would receive over a lifetime. So it was important to think of cardiology and the whole network of care, and not just focus on the understandably high profile given to surgery
- how would this new review link in to the wider process of specialised commissioning?
- there was a risk of service deterioration even during the next 12 months – it would be essential to take steps where possible to stabilise the existing service, through better more formal networks, and adoption of those standards which were not contentious or likely to change. This ought to be a "bottom up" service-led approach, though networking arrangements might require some central support at first
- NHS England should work with the professions to consider how more comprehensive data collection/dissemination could help

- if the new review were to be built around "fixed points" – as the Board paper seemed to suggest – then the clinical validity of these fixed points was a key consideration. A significant number of centres could potentially fail to satisfy the "fixed points" – what would be the immediate/medium/longer term implications of that? Would there be an opportunity to address shortcomings?
- it was noted that there had been a review of transplantation services submitted to Sir Bruce Keogh in March 2013, and that this would be relevant to the work of the new CHD review
- the role of senates should not be overlooked, (especially in developing networks), nor the contribution of clinical reference groups (CRGs). There were key individuals who needed to be involved (including CRG chairs and regional medical directors). In considering his clinical advisory panel (and supporting arrangements) Bruce Keogh would need to reflect on this.
- there would be lessons to learn from the way in which other bodies had engaged with their stakeholders on Safe and Sustainable (for example, Royal College of Nursing had run workshops three times per year to hear from its members in surgical centres)
- NHS England should consider how to identify, hear from and reflect the views of "parent spokespeople" who could give balanced, authoritative accounts of their own experience, and the importance of designing services not just for today but for future generations
- there may be potential for a UK- or England– wide network of care with geographical subsets – possibly organised under a single contract, for the provision of a national service, to mirror the single national commissioner (NHS England).
- NHS England would need to properly understand and work continuously with local government and the health oversight and scrutiny committees, to mitigate the risk that any decision could be appealed by any local authority at the end of the process
- without seeking to deny the room for improvement, clinicians wanted the language of this review to recognise the huge strides that had been made in this specialty since the 1990s – the current quality of the service, how hard all professions had worked to make the necessary changes